General Pharmaceutical Council

Fitness to Practise Committee

Principal Hearing

Hybrid hearing

13th- 16th May 2024; 20th – 22nd May 2024; 4th June 2024, 26th June 2024, 28th June 2024, 9th July 2024; 12th July 2024, 15th – 19th July 2024, 16th August 2024, 6th September 2024, 27th September 2024, 3rd October 2024, 7th - 8th October 2024, 21st - 23rd October 2024

Registrant name:	Mobolaji Adeyinka Onafuwa
Registration number:	2053101
Part of the register:	Pharmacist
Type of Case:	Misconduct
Committee Members:	Mr Philip Geering (Chair) Ms Vaishally Patel (Registrant Member) Ms Nalini Varma (Lay Member)
Legal Adviser:	Mr Ralph Shipway
Committee Secretary:	Ms Zainab Mohamad / Mr Adam Hern / Ms Sameen Ahmed
Registrant:	Present at Stage 1 evidence/submissions only and thereafter absent - not legally represented
General Pharmaceutical Council:	Represented by Dr F Graydon, Counsel

Facts proved:	1, 2 including 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 3 including 3.1, 3.2, 3.3, 3.4, 4 including 4.1, 4.2, 4.3, 4.4, 4.5, 5 including 5.1., 5.2, 5.3, 5.4, 5.6, 5.7, 5.8 and 6 7 including 7.1, 7.2, 7.3, 7.4, 7.5, 7.6, 7.7, 7.8, and 8.
Facts proved by admission:	None
Facts not proved:	None
Fitness to practise:	Impaired
Outcome:	Removal
Interim measures:	Interim Measure of Suspension.

This decision including any finding of facts, impairment and sanction is an appealable decision under *The General Pharmaceutical Council (Fitness to Practise and Disqualification etc. Rules) Order of Council 2010*. Therefore, this decision will not take effect until 22 November 2024 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.

Particulars of Allegation (as amended)

You, a registered pharmacist, during the course of your engagement as a Pharmacist Independent Prescriber with UK Meds Direct Limited, Unit 3, Castlebridge Office Village, Castle Marina Road, Nottingham, Nottinghamshire, NG7 1TN ("UK Meds Direct Ltd")

1. Between 20 May 2019 and 15 October 2019, you prescribed and/or approved at least 7684 prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring.

2. In relation to 1 above, you failed to prescribe medicines in accordance with and/or pay due regard to the relevant guidance on prescribing from the General Medical Council ("GMC"), the Royal Pharmaceutical Society ("RPS") and/or the General Pharmaceutical Council ("GPhC") in that you prescribed in circumstances where you:

2.1. failed to obtain adequate information in relation to the patients' health in advance of prescribing;

2.2. relied principally on the information received in an online questionnaire;

2.3. failed to access and/or attempt to access patients' General Practitioner ("GP") medical records and/or specialist clinic records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

2.4. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

2.5. failed to adequately consider the possibility of medication dependence and misuse;

2.6. failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring; and/or

2.7. failed to put adequate safety-netting in place.

3. In relation to 1 above, you prescribed in circumstances where the UK Meds Direct Ltd prescribing model or service was incapable of supporting safe prescribing decision in that:

3.1. no face-to-face consultation took place other than the use of a questionnaire;

3.2. patients were allowed to pre-select the medicine, strength, and quantity they desired;

3.3. patients provided information primarily through a questionnaire;

3.4. the questionnaire at 3.3 above could be easily manipulated by patients as it notified them of answers which could prevent the supply of the medication they desired and permit the patient to change their answer.

4. In relation to 1 above, you prescribed a significant portion of prescriptions in circumstances where the time taken would not have been sufficient for you to clinically evaluate the suitability of the medicines to the patient including:

4.1. read, consider and assimilate the completed questionnaire;

4.2. consider if it was clinically necessary to check with the patients' GP and/or contact the GP;

4.3. consider if it was clinically necessary to contact the patient and/or conduct a face-to-face consultation with the patient;

4.4. consider if it was necessary to check the clinical background of the patient and/or check the clinical background;

4.5. consider the steps you ought to take to prescribe in accordance with UK prescribing guidance as set out at 2 above.

5. In relation to 1 above, on or around 23 May 2019, you prescribed 100 tablets of Dihydrocodeine 30mg to Patient 10, in circumstances where you:

5.1. knew or should have known that

5.1.1. he patient had already made repeated orders on 18 previous occasions for the same medicine from UK Meds Direct Ltd;

5.1.2. the patient put the same or very similar answers into each questionnaire.

5.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

5.3. relied principally on questionnaire answers whereby it was unverified information;

5.4. failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

5.5. failed to request a face-to-face consultation with patients in order to examine the clinical need for medication;

5.6. failed to adequately consider the possibility of medication dependence and misuse;

5.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or

5.8. failed to put adequate safety-netting in place.

6. In relation to 1 above, you prescribed all or some of the medicines in Schedule A to patients in approximately the quantities outlined in that schedule on the basis of an online questionnaire when they are unsuitable to prescribed on that basis.

7. On some or all of the occasions set out in Schedule B you prescribed the medicines to the patients outlined in that schedule in circumstances where you:

7.1. knew or should have known that the patient had already made repeated orders for the same medicine from UK Meds Direct Ltd;

7.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

7.3. relied principally on questionnaire answers whereby it was unverified information;

7.4. failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

7.5. failed to request a face-to-face consultation with patients in order to examine the clinical need for medication;

7.6. failed to adequately consider the possibility of medication dependence and misuse;

7.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or

7.8. failed to put adequate safety-netting in place.

8. Your approach to prescribing in all or some of the allegations 1 to 7 was transactional in that you were processing patient requests by reference to a patient completed questionnaire rather than prescribing in accordance with UK prescribing guidance.

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

Schedule A

Medicine	**No of prescriptions (approx.)**
Z-Drugs	2,703
Opioids	3,514
Modafinil	746
Amitriptyline	68
Propranolol	376
Orlistat/Xenical	101
Promethazine	19
Metformin	119
Ventolin	648

(End Schedule A)

Schedule B

Date (s)	Medicine/quantity	Patient Customer ID
8 July 2019	14 tablets of zopiclone 3.75mg	7867
9 June 2019 and/or 15 August 2019	7 tablets of zolpidem 5mg	27089
4 June 2019	14 tablets of zopiclone 7.5mg	8849
8 June 2019; 17 July 2019; 11 September 2019; and/or 8 October 2019	14 tablets of zopiclone 7.5 mg	156990
15 August 2019; 4 September 2019 and/or 25 September 2019	100 tablets of co-codamol (Solpadol) 30mg/500mg	20888
29 July 2019; 16 August 2019 12 September 2019; and/or 28 September 2019	100 tablets/capsules of kapake 30mg/500mg	8976
5 June 2019; 4 July 2019; 12 August 2019 and/or 27 August 2019	100 tablets of codeine 30mg	63029
17 July 2019; 1 August 2019; 11 September 2019; and/or 25 September 2019	100 tablets of Dihydrocodeine 30mg	180058

Date (s)	Medicine/quantity	Patient Customer ID
8 June 2019	28 tablets of amitriptyline 25 mg	8314
12 October 2109	28 tablets of amitriptyline 25 mg	65277
15 August 2019	30 tablets of modafinil 100 mg	42489
2 July 2019; 7 August 2019; and/or 10 October 2019	10 tablets of modafinil 200mg	77006
22 September 2019	84 tablets of propranolol 40mg	159152
8 July 2019	84 tablets of propranolol 100mg	100896
9 July 2019	252 capsules of orlistat 120 mg	66543
7 June 2019	112 tablets of metformin 850mg	127384
11 August 2019	2 Ventolin (inhalers) 100mcg	7950
23 May 2019	100 tablets of dihydrocodeine 30mg	206117
12 September 2019 and/or 12 October 2019	100 tablets of dihydrocodeine 30mg	220237
7 August 2019	100 tablets of dihydrocodeine 30mg	16735
27 June 2019 and/or 1 August 2019	100 tablets of dihydrocodeine 30mg	157921
23 July 2019	100 tablets of codeine 30mg	4247
30 June 2019	200 tablets of co-codamol 30/500mg	2033

(End of Schedule B)
(End of Allegation)

Documentation

Document 1 - GPhC Principal Hearing bundle indexed and paginated 1 – 929 (but excluding pages 23 to 180 inclusive, being two reports by Ms 1 dated 20/6/2022 and 15/5/2023 - see below)

Item Electronic access to GPhC Exhibits SO/01 and SO/02, being two large Excel Spreadsheets

Document 2 - GPhC Supplementary Principal Hearing Bundle indexed and paginated 1 – 8 (Prescriptions for Patient 10) (provided to committee 14/5/2024)

Document 3 - GPhC Combined Statement of Case and Skeleton Argument dated 9/5/2024

Document 4 - Registrant's Witness Statement dated 13/5/2024

Document 5 - Registrant's Witness Statement dated 15/5/2024 (provided to committee 14/5/2024)

Document 6 - Agreed Registrant's bundle indexed and paginated 1 – 575.

Document 7 - Registrant's Contested Bundle (pages 1-1847).

The committee was provided with a bundle entitled the 'Registrant's Contested Bundle'. The Registrant applied for it to be admitted in evidence. The GPhC objected to its admission. The committee heard submissions on the matter and accepted the advice of the Legal Adviser. Having done so, the committee reached the following conclusions in respect of different parts of the bundle (15/5/2024):

Exhibit MA/06: UK Meds Disclosure Received 1 February 2023 – admitted. The Registrant referred to MA/06 as "critical" to his defence including comparisons between his prescribing and that of others at UK Meds. The committee took the view that the information in MA/06 was relevant since it set in context the factual allegations against the Registrant, and it would be fair to allow him to refer to this if he so

wished as part of his case. It therefore granted the application to **Admit** MA/06.

Email from the Registrant, attaching a Reed employment agency legal caseworker job description and qualifications. The committee **Refused** to allow this document to be admitted in evidence as it was not relevant. This is further explained in the numbered paragraphs under the list of items the committee had sight of during the hearing.

Copy letter Registrant to the GPhC CEO/Registrar dated 16/3/2024 registering a complaint (7 pages). In addition, the committee was provided with a copy letter from the Registrant to the CEO/Registrar dated 19/3/2024. The letters set out his complaints about the GPhC's handling of the investigation and its case against him. The committee was satisfied that the two letters were relevant since they in part set out the Registrant's defence to the allegations against him and it would be fair to the Registrant, particularly as he was unrepresented, to **Admit** both letters.

Document 8 - Letter GPhC to Brabners Solicitors (acting for UK Meds) dated 7/12/2022 (provided to committee 14/5/2024)

Document 9 - Printed extract, PDA website, regarding insurance cover, headed *"Independent Prescribing & Differentiated Diagnosis"* (two pages) (admitted as evidence by the committee on the application of the Registrant on 14/5/2024

Document 10 - Printed extract, Lloyds Pharmacy website, headed *"Meet the LloydsPharmacy Online Doctor clinical team"* (9 pages) (admitted as evidence by the committee on the application of the Registrant on 14/5/2024)

Document 11 - Printed extract, Google search *"is metformin harmful"* (six pages) (admitted as evidence by the committee on the application of the Registrant on 16/5/2024)

Document 12 - Printed extract Care Quality Commission website starting *"CQC regulates providers of online primary care services…"* (1 page) (admitted as evidence by the committee on the application of the Registrant on 16/5/2024)

Document 13 - Supplementary Principal Hearing Bundle – Inspection Documents, SOPs, Internet Logo (indexed and paginated 1 – 181) (provided to committee at its request 26/6/2024)

Document 14 - Supplementary Principal Hearing Bundle – relevant BNF Extracts (indexed and paginated 1 – 35) (provided to committee at its request 26/6/2024)

Document 15 - GPhC published guidance *"Guidance for registered pharmacies providing pharmacy services at a distance including on the internet"* updated January 2018 (provided to committee 28/6/2024)

Document 16 - GPhC published *"Standards for pharmacy professionals"* dated May 2017, (provided by the GPhC to the committee on 15/7/2024).

Document 17 - GPhC published *"Standards for registered pharmacies"* revised June 2018, provided by the GPhC to the committee on 15/7/2024.

Document 18 - GPhC published guidance "*Standards for registered pharmacies"* Revised June 2018

Document 19 - GPhC 'Proceeding in Absence Bundle' provided for the hearing on 3/10/2024

Document 20- Copy emails between the Committee Secretary and the Registrant on 3/10/2024 and 4/10/2024 – provided to the committee for the purposes of an application on 7/120/2024 to proceed in the Registrant's absence and which are listed in detail below.

Document 21- GPhC 'Proceeding in Absence Bundle' provided for the hearing on 21/10/2024 (paginated 1-74)

Document 22- GPhC telephone File Note dated 18/10/2024

Document 23- GPhC 'Supplementary Proceeding in Absence Bundle' provided for the hearing on 21/10/2024 (paginated 1 – 10)

Document 24- GPhC telephone File Note dated 21/10/2024 @ 16:45pm

In addition, the committee had sight of the following:

1. The panel Chair had a copy of Case Management Directions dated 11/4/2024 (hearing to be held in person), and an email dated 7/5/2024 seeking a ruling to allow two witnesses for the GPhC to give evidence remotely, an application that was refused in Case Management Directions dated 8/5/2024 although subsequently the committee allowed some witnesses to give evidence by video link as circumstances changed.
2. Extract from the Reed Employment Agency website showing job description for a role within regulatory work. As referred to above, the Registrant applied to have this admitted in evidence arguing it was relevant to show the sort of skills and qualifications that might be expected of someone in the role of the GPhC witness Ms 4. This was opposed by the GPhC. The committee refused to admit this document as evidence on the basis that it was not relevant: it did not directly relate to the role of Ms 4, the GPhC's Lead Case Officer, who was scheduled to give evidence and could be directly asked about her skills and qualifications.
3. Statement of Ms 5, a senior manager at the GPhC, dated 20/5/2025 – this statement was considered by the committee in PRIVATE. It was considered by the committee in the context of an adjournment application made on behalf of the GPhC and did not form part of the evidence presented to prove the allegation.
4. Statement of Ms 6, member of staff with the GPhC, dated 31/5/2024 with documentary exhibits attached (totalling pages 1 – 37). This was provided to the committee at a time when it was thought the GPhC's witness Ms 4 would be unavailable to give oral evidence. Ms 6 prepared a statement in anticipation of being presented as a substitute witness for the GPhC. In the event, Ms 4 was able to give evidence, and the statement of Ms 6 was <u>not</u> admitted as evidence or relied upon by the GPhC.
5. Short YouTube footage: late in the fact-finding stage, the Registrant applied to have admitted a short video clip of a young person completing a mental mathematics challenge at high speed (19 relatively difficult questions in 60 seconds). The

Registrant's submission was that the video was relevant to Particular 4 as it showed how, with experience and training, the human mind can work at high speed. On behalf the GPhC, it was submitted that the video clip was not relevant and should not be admitted as evidence. The GPhC also questioned the fairness of admitting further evidence at such a late stage. The committee viewed the footage and accepted the advice of the Legal Adviser. The committee concluded that the video footage was not relevant: it was a demonstration of someone other than the Registrant demonstrating a quickness of mind, and the demonstration was of mathematics not the consideration of factors that may go to making a prescribing decision. The committee refused the application.

Witnesses

Ms 1, expert witness gave sworn evidence at facts stage on behalf of the GPhC – she gave evidence by video link.

Ms 2, Professionals Regulations Manager (Legal) at the GPhC gave sworn evidence at facts stage on behalf of the GPhC - she gave evidence in person.

Ms 3, Senior Clinical Advisor and Specialist Inspector at the GPhC gave sworn evidence at facts stage on behalf of the GPhC – she gave evidence by video link.

Mr 1, Senior Data Analyst and Insight Manager at the GPhC gave sworn evidence at facts stage on behalf of the GPhC – he gave evidence by video link.

Ms 4, Lead Case Officer at the GPhC gave sworn evidence at facts stage on behalf of the GPhC – she gave evidence by video link.

The Registrant chose not to give evidence at the fact-finding stage. Before he took that decision his options had been explained to him in the hearing. In addition, the Legal Adviser had taken time outside of the hearing to explain to the Registrant his options in this regard. Before an adjournment, the Registrant had indicated he would give evidence. Having reconvened, the Registrant advised the hearing that he had decided not to give evidence: in

large measure, this appeared to be because he did not want to be cross-examined by the GPhC's advocate as he feared, based he said on his past experience of engaging with the GPhC during the past years, that anything he said might be distorted and used against him. He said that he would rely on the various statements he had made to the committee during the hearing. The committee Chair engaged with the Registrant in the hearing to ensure that he understood his options, to reasure him that it would be the committee hearing his evidence and making its own independent judgement about it. The Chair checked with the other panellists and the Legal Adviser that there was nothing further that might be discussed with the Registrant to ensure fairness and to enable him to be in a good position to make a decision. The Registrant stood by his decision not to give evidence but that he would make a statement and would be prepared to answer questions from the committee.

At a later stage, the Registrant suggested that he would be agreeable to Dr Graydon, Counsel for the GPhC, sharing his questions with the committee and for the committee to ask his questions. The committee considered this suggestion. Maintaining the integrity of the process, and confidence in the process, is the priority for the committee. Part of that priority is to maintain the independence of the committee, both actual and perceived. The committee was concerned that it would not be appropriate for it to take on the appearance of cross-examining the Registrant in place of the GPhC. Dr Graydon indicated that he was of the same view: his role was to cross-examine on behalf of the GPhC and any questions he had in mind were to that end. The committee decided, therefore, that it would not be appropriate for it to receive and use Dr Graydon's questions prepared for cross-examination. The committee anticipated that it would ask questions of the Registrant. The panel also anticipated turning to the Legal Adviser to ask him whether there were any other issues on which the Registrant might make a statement or be questioned upon. The committee decided that it would, given Mr Onafuwa's suggestion, also invite Dr Graydon whether he thought there were any broad areas the committee might wish to invite Mr Onafuwa to comment on or be questioned upon. The committee adopted this approach. In the event, after extensive questioning by the committee, Dr Graydon suggested just one area relating to *"cut-off times"*.

Determination

Introduction

1. This is the written determination of the Fitness to Practise Committee at the General Pharmaceutical Council ('the GPhC').

2. The hearing 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 statutory overarching objectives for these regulatory proceedings are:

   a. To protect, promote and maintain the health, safety and well-being of the public,

   b. To promote and maintain public confidence in the professions regulated by the, GPhC and

   c. To promote and maintain proper professional standards and conduct for members of those professions.

4. The committee also has regard to the guidance contained in the GPhC's *Good decision making: Fitness to practise hearings and outcomes guidance* as revised March 2024.

5. A Principal Hearing has up to three stages:

   Stage 1. Findings of Fact – the committee determines any disputed facts.

   Stage 2. Findings of ground(s) of impairment and impairment – the committee determines whether, on the facts as proved, a statutory ground for impairment is established and, if so, whether the Registrant's fitness to practise is currently impaired.

   Stage 3. Sanction – the committee considers what, if any, sanction should be applied if the Registrant's fitness to practise is found to be impaired.

Conflict of Interests

6. At the outset of the hearing, the panel Chair advised the parties that members of the panel had previously sat on interim order hearings concerning UK Meds, the pharmacy involved in this case, though they had not sat on any interim order hearing involving this Registrant. Neither party took exception to this. The panel was satisfied that no issue of conflict arose and that it could properly and fairly hear and determine this case and would do so on the evidence and submissions presented in the hearing.

Service of Notice of Hearing

7. The committee has seen a letter dated 12/4/2024 from the GPhC headed 'Notice of Hearing' addressed to the Registrant. No issue was taken by the Registrant regarding notice. He acknowledged that he had received the letter and was able to proceed.

The Registrant: unrepresented and attending by video link

8. The Registrant advised that he was not in a position to have legal representation but was prepared and ready to represent himself. The committee had seen statements prepared by the Registrant and was satisfied he was able to represent himself. During the course of the hearing, the committee allowed time for the Registrant to prepare, for example questions to witnesses, and arranged for the Legal Adviser on a number of occasions to spend time with the Registrant outside of the hearing to explain to him the process and how he might chose to approach it, for example, with regard to the questioning of witnesses. During the hearing the committee Chair monitored and checked with the Registrant his engagement with the process.

9. The Registrant explained that despite the direction for the hearing to be held in person he did not have the resources to travel to the hearing venue and to stay overnight for the hearing. Hence, he was appearing by video link arranged for him by

the committee secretary. The panel was satisfied that the appropriate course was to press-on with the hearing with the Registrant attending by video link.

10. The Registrant confirmed his registration number.

Application to amend the particulars of allegation

11. The committee heard an application on behalf of the GPhC under Rule 41 to amend Particular 1 of the Allegation.

12. Particular 1 read in part: *"…you prescribed and/or approved at least 11,764 prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring."*

13. The application was to delete the number *"11,764"* and replace it with *"7,684".* It was submitted that this better reflected the evidence, and the amendment would not unduly prejudice the Registrant.

14. The Registrant opposed the application arguing, in summary, that it was, in his view, another example of how the GPhC did not understand the evidence, was not able to appropriately analyse the evidence, and was repeatedly changing what was alleged against him.

15. The committee accepted the advice of the Legal Adviser.

16. The committee was satisfied that the amendment could be made without causing prejudice to the proceedings. The statement of Ms 4 dated 31/10/2023 at paragraph 46 (in the GPhC Principal Hearing Bundle) provided the evidence for the substitute number whilst an earlier paragraph (paragraph 9) provided the earlier number but expressed to be in a different context to that of Particular 1.

17. **Accordingly, the committee granted the application to amend Particular 1 to read in part as follows: *"…you prescribed and/or approved at least 7684 prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring."***

Applications to admit additional evidence

18. During the hearing, the committee was provided with a number of additional documents, some of which were agreed between the parties (such as GPhC guidance documents) and which the committee admitted in evidence, and some of which were contested. In relation to those documents that were contested, the committee received submissions from the parties, accepted the advice of the Legal Adviser, and made decisions regarding admissibility that are recorded above in the list of documents before the committee and the paragraphs beneath the list of documents.

Application for the hearing to be held in Private

19. At the direction of the committee, parts of the hearing were held in private under Rule 39(3) and did so without objection from either party. In doing so, the committee accepted the advice of the Legal Adviser.

20. The committee's direction for parts of the hearing to be heard in private applied to:

    a. The Registrant when speaking about aspects of his personal, family and financial affairs affecting his ability to instruct a representative and attend the hearing, and
    b. Discussions between the parties and the committee regarding the availability of Ms 4 in the light of personal circumstances affecting her availability to attend the hearing.

Complaints by the Registrant against the GPhC and GPhC staff

21. At an early stage of the hearing the Registrant referred to complaints he had made against the GPhC and GPhC staff for the way the case investigation had been handled and the adverse impact this had had on him.

22. At subsequent times he advised the committee that the GPhC had informed him:

    a. That his complaint would be dealt with through the Fitness to Practise hearing, and, on challenging this,
    b. That consideration of his complaint would be paused pending the conclusion of the Fitness to Practise hearing, and then,
    c. That his complaint had been closed.

    It was evident that these differing messages, some sent during the course of the hearing at Stage 1, caused the Registrant confusion and considerable anguish.

23. The committee indicated to Dr Graydon that the GPhC communications during the hearing to the Registrant were significantly unhelpful because of the adverse impact on the Registrant and how this then affected the hearing. Dr Graydon was invited to speak with those instructing him.

24. Subsequently, the Registrant told the committee that he had been advised by the GPhC that there had been a miscommunication by the GPhC and that his complaints had not been closed but consideration of them were suspended pending the conclusion of the Fitness to Practise hearing.

25. For the avoidance of doubt, the committee noted during the hearing, and records here:

    a. The committee is not a complaints resolution body and does not have as any part of its role the resolution of complaints the Registrant may have against the GPhC,
    b. That its statutory remit is to assess and, if appropriate, address the Registrant's fitness to practise based on the evidence available to it,

c. That without expressing a definitive view, there was merit in the investigation of the complaints matter being suspended pending the conclusion of the Fitness to Practise hearing, and
d. The committee hoped that the Registrant would not be further troubled by communications on this issue during the hearing.

Interim Order

26. Within the Registrant's bundle, and in statements made by him to the committee, it was disclosed that he was subject to an interim order, and that there was a review of the interim order due, or overdue, during the hearing.

27. The committee in its decision-making placed no relevance or weight on the fact that he was subject to an interim order.

28. The committee indicated that it did not think it appropriate for this Principal Hearing panel of the committee to consider the Interim Order Review.

Registrant's response to Particulars of Allegation

29. The Registrant denied the entirety of the Allegation.

30. Accordingly, the committee went on to receive evidence and submissions regarding the Allegation.

Statement of Ms 4 dated 31/10/2023.

31. At the start of her evidence, Ms 4 was asked if her statement was accurate. She confirmed that it was save in two respects, namely:

a. Paragraph 17 which referred to the date *"21 May 2020"* she advised it should read *"21 May 2019"*, and

b. Paragraph 26 which refers to a patient obtaining medication on *"seven occasions"*, she advised it should read *"six occasions"*.

32. The committee was content that these amounted to no more than minor matters which did not undermine the weight of her evidence.

Application to proceed in the absence of the Registrant – Stage 1

33. The Registrant attended from the start of the hearing to the completion of the evidence and submissions at Stage 1. On 19/7/2024, with the Registrant present, the hearing adjourned for the committee to meet in private to deliberate and make findings at Stage 1, fact finding. The committee met in private, deliberated, made decisions regarding the factual allegations, and produced a written determination setting out its findings and decisions.

34. The hearing resumed on 3/10/2024 in anticipation of the committee announcing its decisions on facts and handing down the written determination. When the hearing resumed, Dr Graydon attended on behalf of the GPhC but the Registrant was absent. Dr Graydon made an application for the hearing to proceed in the absence of the Registrant under Rule 25. In doing so, the committee was provided with a GPhC 'Proceeding in Absence Bundle' (paginated 1 – 67).

35. The Committee accepted the advice of the Legal Adviser.

36. The Committee decided to proceed in the absence of the Registrant. In doing so, the committee relied on the following:

a. The Committee has found good service of the Notice. The committee has seen a copy of a Notice of Hearing dated 29/8/2024 which sets out the arrangements for the resumed hearing starting on today's date.

b. It is apparent from email exchanges between the Registrant and the Committee Secretary that not only has the Notice of Hearing been sent out but that he is aware of the Principal Hearing resuming today, 3/10/2024 – see in particular, the Registrant's email dated 24/9/2024 at 12:13pm.

c. The Proceeding in Absence Bundle includes an email from the Committee Secretary dated 24/9/2024 recording her telephone conversation with the Registrant that day. She records that he said he *"will not be resuming* [sic] *his Principal Hearing as his duty is done and they* [the committee] *no longer need him"* and that there *"was nothing left for him to say."*

d. The Committee Secretary asked the Registrant to confirm his position in an email. By email dated the same day, 24/9/2024, the Registrant, with his customary courtesy, wrote the following: "*I now lack the strength, and resources, to continue engaging with the Principal Hearings…I am content for the rest of the Principal Hearings to be concluded in my absence. I eagerly await news of my complete exoneration and vindication."*

e. The Notice of Hearing sets out his options for attending and representing himself, and also indicates that the committee may decide to proceed if he does not attend.

37. In the light of the above, the Committee concluded that the Registrant has chosen to voluntarily absent himself from this hearing. He has not applied for an adjournment, and there is no information to suggest an adjournment would result in the Registrant's attendance in future.

38. The committee is also satisfied that there is a public interest in the hearing proceeding. There is a public interest in the expeditious disposal of cases.

39. The committee has regard to the statutory objectives for the hearing, the age of the case and, at least for today, the purpose of the hearing which is to announce and hand down the committee's written determination.

40. In addition, the committee notes that the Registrant's position, as set out in his email, is consistent with comments he made before the hearing previously adjourned, indicating that he felt he had said all that he could say on his behalf and that he would trust the committee.

41. Accordingly, the committee decided to proceed in the absence of the Registrant for today's purposes, namely announcing its Stage 1 fact finding decisions and handing

down the written determination before adjourning to the next hearing day (7/10/2024).

42. The committee, in announcing this decision, indicated that it would wish to revisit the issue of proceeding in absence before receiving submissions on Stage 2 (grounds and impairment) and again before receiving submissions on Stage 3, sanctions, if that stage is reached and if the Registrant continues to be absent.

Application to proceed in the absence of the Registrant – Stage 2

43. On 7/10/2024, the hearing resumed for the committee to receive evidence/ submissions on the issue of the ground alleged of misconduct and on the issue of impairment.

44. The Registrant was not present. At the behest of the committee a renewed application was made by the GPhC for the hearing to proceed in the absence of the Registrant. The committee received and accepted the advice of the Legal Adviser.

45. The committee determined to proceed with the hearing in the absence of the Registrant.

46. In reaching this decision, the committee had the benefit of the documentation contained in the GPhC's 'Proceeding in Absence Bundle' reviewed on 3/10/2024, in particular the Notice of Hearing dated 29/8/2024. In addition, the committee had sight of an exchange of emails between the Committee Secretary and the Registrant, in particular the following emails:

    a. Email 3/10/2024 @ 4:32pm from the Committee Secretary to the Registrant attaching the Stage 1 written determination.

    b. Email 3/10/2024 @ 10:35pm from the Registrant to the Committee Secretary which reads:

        "Thanks for sending me the determinations. I have had a look at the file. I trust you will also send me the outcome of the next stage, when available."

c. Email 4/10/2024 @ 9:23am from the Committee Secretary to the Registrant, assuring him she would send him the Stage 2 determination and asking him to indicate whether he would be attending this hearing on 7/10/2024.

d. Email 4/10/2024 @ 1:46pm from the Committee Secretary to the Registrant providing him with the video link for the hearing on 7/10/2024.

47. Having seen the above, the committee is satisfied that:

a. The Registrant has received a copy of the Stage 1 written determination and the committee's findings of facts proved. Indeed, by his references to *"determinations"* in the plural indicates he has received both the Stage 1 determination as prepared for the hearing on 3/10/2024 and the Stage 1 determination with additional paragraphs recording the committee's decision to proceed in his absence on 3/10/2024.

b. He can be aware from the determination that the committee would revisit the issue of proceeding in his absence at the start of Stage 2.

c. The Registrant has chosen not to attend the Stage 2 hearing – this is evidenced by his request for the Stage 2 determination to be sent to him and without asking or indicating anything further.

d. He has not made any application for an adjournment.

e. There is no reason to conclude that were the committee to adjourn the hearing he would subsequently attend for the Stage 2 hearing.

f. There is a significant public interest in the case proceeding and the GPhC is ready to do so.

g. That there is no clear reason to adjourn and the appropriate conclusion is therefore to proceed with the Stage 2 hearing in the Registrant's absence.

48. Accordingly, the committee determined to proceed with Stage 2 in the absence of the Registrant**.**

49. The committee makes clear that in the event this case reaches Stage 3 (consideration of sanction) the Registrant has the right to attend the hearing to present evidence

and/or to make statements and submissions. In the event that he does not attend, the committee will again re-consider whether or not to proceed in the absence of the Registrant.

Application to proceed in the absence of the Registrant – Stage 3

50. On 21/10/2024, the hearing resumed for the committee to receive evidence/ submissions on Stage 3 of these proceedings, determining the appropriate sanction/outcome to impose.

51. The Registrant was not present when the hearing resumed on 21/10/2024.

52. At the behest of the committee a renewed application was made by the GPhC for the hearing to proceed in the absence of the Registrant. The application was supported by a 'Proceeding in Absence Bundle – 21-23 October 2024' and a copy GPhC File Note dated 18/10/2024.

53. The Proceeding in Absence Bundle prepared for the Stage 3 hearing showed that the Stage 2 determination had been emailed to him, that there had been emails to him (dated 10/10/2024 and 17/10/2024) asking him whether he would be attending the Stage 3 hearing, and a video link for the hearing had been emailed to him on 18/10/2024. There had been no response from the Registrant to any of these communications. It is noted that in one of the emails, the Stage 3 hearing was incorrectly referred to "resume on 23rd". A File Note of 18/10/2024 recorded that the GPhC telephoned the Registrant on that date but there was no answer to the call and no voicemail facility.

54. On further questioning by the committee, it emerged that (a) a hard copy of the Stage 2 determination had not been sent to the Registrant, (b) the email sending the Stage 2 determination had not been opened, and (c) the email sending him the video link for the resumed hearing had not been opened.

55. The committee took the exceptional step of adjourning the application for the hearing to proceed in the Registrant's absence. It did so given the stage of the proceedings, the seriousness of the hearing (the GPhC's written Skeleton sought

removal as the appropriate sanction), and to ensure fairness particularly to the Registrant who had been very engaged with Stage 1.

56. When adjourning, the committee invited the GPhC to arrange for a hard copy of the Stage 2 determination to be couriered to the Registrant for urgent delivery, that he should again be emailed and telephoned, and that in so doing, the Registrant should be reminded the hearing was resumed on that day, 21st October 2024 and was scheduled for the following two days, he has a right to attend, he could attend by video link or by telephone, that he could make oral or written representations, that the Legal Adviser was available to talk to him, and that he should be invited to indicate whether or not he intended to attend if that was his wish.

57. Having resumed the hearing, the committee was further provided with the following:

    a. GPhC 'Supplementary Proceeding in Absence Bundle' provided for the hearing on 21/10/2024 (paginated 1 – 10)

    b. GPhC telephone File Note dated 21/10/2024 @ 16:45pm

58. From this material it was apparent that:

    a. A hard copy of the Stage 2 determination had been sent and delivered to the Registrant's home address on the afternoon of 21/10/2024 (the day the hearing resumed for Stage 3).

    b. Its receipt at his address was signed for in the name of "Mobo" (an abbreviation of the Registrant's first name).

    c. The hard copy determination was accompanied by a covering letter that provided him with relevant information and an invitation that he advise by 9:30am 22/10/2024 whether or not he intended to engage with the hearing.

    d. There had been no response by him to the letter by 10:30am 22/10/2024.

    e. He had been emailed again on 21/10/2024 using his personal email address, the emails had been delivered but no response had been received.

    f. There had again been telephone calls made to his mobile phone number but none had been taken and there was no voice mail facility.

59. In the light of the above, the GPhC renewed its application for the hearing to proceed in the Registrant's absence.

60. The committee received and accepted the advice of the Legal Adviser.

61. The committee determined to proceed with the hearing in the absence of the Registrant.

62. In reaching this conclusion, the committee had regard to the following:

    a. The Notice of Hearing dated 29/8/2024 had been issued and it was apparent the Registrant had received it. The Notice provides the dates of the hearing, including 21 – 23 October 2024, and includes a caution about "What happens if you do not attend the hearing?" to the effect that hearing may continue in his absence including as far as imposing a sanction.

    b. The committee is satisfied that all reasonable efforts have been made to ensure the registrant knows that the hearing has resumed and that he has the right to attend. The committee is so satisfied despite the single email that incorrectly refers to resuming on 23rd October. The date of 21 – 23 October was agreed with the Registrant when forward dates were being identified; it is given in the Notice of Hearing; the dates are referred to in subsequent emails including the emails and letter delivered on 21/10/2024. If the Registrant was in any uncertainty, he could readily clarify the matter by communicating with the Committee Secretary as he has done on other occasions.

    c. The Registrant's comments to the committee during the closing submissions at Stage 1 signalled that he may not continue engaging with the hearing on the basis that he felt he had said all that he could say.

    d. His email of 24/9/2024 maintained this stance when he explicitly wrote "I am content for the rest of the Principal Hearing to be concluded in my absence", albeit at that stage he continued to hold out that he would be exonerated which subsequently did not happen.

    e. His email of 2/10/2024 explicitly maintained his stance when he wrote (in advance of Stage 2) "As previously stated, I am content for the remainder of the

Hearings to be concluded in my absence, having been afforded the opportunity to state my case clearly, and to answer the Chair and Committee's questions already."

63. Whilst it may have assisted the committee to have a more recent expression of his wishes, there is a strong inference that he has chosen to disengage from the proceedings given his earlier statements and the absence of any response to more recent communications from the GPhC.

64. He knows he may provide written representations having done so previously and knows the hearing may be adjourned as has previously happened, yet he has provided no representations for an adjournment at this time.

65. The committee concludes that an adjournment now would not result in his attendance at a future date.

66. The committee concludes that he has voluntarily absented himself from the hearing.

67. There is a strong public interest in proceeding.

68. In the absence of a good reason to not proceed, the committee decided that the appropriate course is to proceed.

69. Accordingly, the committee determined that it would proceed with Stage 3 and the conclusion of the case in the absence of the Registrant.

Background

70. UK Meds Direct Ltd ("UK Meds") was a pharmacy registered with the General Pharmaceutical Council ("the GPhC") that provided online pharmacy services to patients between the period from the 2nd October 2017 to the 6th September 2021.

71. The remote prescribing model operated by UK Meds involved a patient questionnaire-based assessment operating through a web-based platform.

72. In essence, this meant that:

    a. A member of the public could log onto and register with UK Meds.

b. The member of the public could then request medication by completing an online patient questionnaire that was then electronically submitted.

c. The completed patient questionnaire could then be reviewed online by a pharmacist qualified to issue prescriptions (a Pharmacist Independent Prescriber, 'PIP').

d. Having reviewed the patient questionnaire, the PIP's options were, in summary, to 'Approve' the order for medication and to issue a prescription for medication (the prescription being an electronic record, not a paper prescription), to 'Refuse' the order, or to 'Refer' the order to the UK Meds Clinical Lead for further consideration.

e. When a PIP issues a prescription, it is then passed on to others to be dispensed, and, once dispensed, packaged and despatched to the member of the public by post or courier – there were *"cut-off times"* for the twice daily collection of packages taken for delivery to patients.

f. The member of the public pays for this service.

73. The pharmacy did not have an NHS contract and so did not offer any NHS services or dispense NHS prescriptions.

74. On 15/2/2018 UK Meds was subject to an unannounced inspection visit by the GPhC less than five months after the pharmacy was first registered. At that time the pharmacy operation was relatively limited but included the provision of opiate painkillers. The outcome of that inspection was that UK Meds was rated as *"Satisfactory".*

75. On 29/3/2019 the GPhC issued an Improvement Notice against UK Meds on the basis that pharmacy services were not being managed or delivered safely in line with expected standards. Concerns had been expressed about UK Meds supplying medication that was clinically inappropriate, or excessive in quantity giving rise to patient harm or serious risk to patient safety.

76. On 14/5/2019 the GPhC conducted a 'Follow-up visit' to UK Meds. At the time of the visit the GPhC noted that UK Meds had extended its operation to seven days a week,

was running at 15,000 orders per month with one or two prescription items per order and that on the day of the follow-up visit by inspectors *"Most prescription items waiting to be checked…were opiate-based pain killers, Z drugs…modafinil."* The note of the visit records that *"The prescriber was said to be able to see a full history i.e. everything prescribed, history of supplies…"* and references *"the online questionnaire used for 'consultations'"*, albeit the prescriber could not see *"where a patient has changed their responses to answers against the online form"*, and that UK Meds was *"aware of guidance recommending that patients could not choose their own medicines ahead of a consultation."*

77. On 20/5/2019, the Registrant started employment with UK Meds as a PIP, working remotely reviewing requests for medication submitted by members of the public.

78. The Registrant worked remotely from home, received training on the UK Meds system, and was able to communicate with other UK Meds prescribers, the Clinical Leads, and managers.

79. The Registrant stated that he qualified and practised as a pharmacist abroad before coming to the UK where he re-qualified and registered with the GPhC in July 2001. He subsequently qualified as an independent prescriber in 2008 and was employed in 2015 as a Pharmacist Independent Prescriber (PIP) including within the setting of a GP Clinic. He described undertaking pharmacist practitioner training through direct apprenticeship with practising GPs over three years starting in 2007.

80. He is described in the UK Meds records as a self-employed contractor who provided contracting services from the 20/5/2019 to the 15/10/2019, a period of 4 months and 27 days.

81. On 12/6/2019, the GPhC wrote to UK Meds to advise that in the light of the UK Meds response to the Improvement Notice, *"we believe you have now met the minimum requirement to satisfy the Improvement Notice"* but that UK Meds should continue to sustain improvements and monitor the service provided, and a further inspection would follow.

82. On 5/7/2019 a pharmacist lodged a concern with the GPhC regarding UK Meds expressing concern that a patient, Patient 10, was able to obtain *"a large supply"* of dihydrocodeine from UK Meds to which they were addicted without liaising with the patient's GP. The concern expressed the view that *"a pharmacy would knowingly and repeatedly supply these medications … is unprofessional conduct."* The Registrant, amongst other prescribers, had issued a prescription for dihydrocodeine to Patient 10. This concern became the subject of an investigation by the GPhC into UK Meds.

83. On the 3/9/2019 a further GPhC inspection was carried out at the pharmacy premises. By this stage, the pharmacy operation had expanded. The inspection outcome revealed that (i) not all standards within the principles of governance, premises, and services including medicines management were met and (ii) statutory enforcement was required.

84. On the 27/9/2019 an improvement notice was served on UK Meds.

85. On 15/10/2019 the Registrant stopped working for UK Meds. His evidence is that he did so because he was concerned about the safety of the pharmacy operation.

86. On 1/11/2019 a further GPhC inspection was undertaken to assess compliance by UK Meds with the September Improvement Notice.

87. On the 8/11/2019 the GPhC Registrar imposed conditions on UK Meds under Section 74D(4) of the Medicines Act 1968 for failing to meet the Improvement Notice requirements. The substantive reasons why it was considered necessary to make the pharmacy subject to conditions highlighted that UK Meds had, *inter alia*, not provided enough evidence:

    a. *"to demonstrate that the prescribing of opioid analgesics, prescription-only hypnotics and modafinil is undertaken in line with good practice guidance and UK national guidelines (including GMC guidance)."*

    b. *"that it identifies and manages all the risks involved with its services. There is evidence that the pharmacy routinely supplies medicines liable to abuse, overuse or misuse primarily on the basis of a patient questionnaire with no input from the patient's usual GP or other healthcare provider."*

c. and insufficient evidence *"that its prescribers: d*

i. proactively share all relevant information about the prescriptions they issue with other health professionals involved in the care of the patient (for example their GP);

ii. communicate with the patient's regular GP in advance of issuing a prescription to confirm that the prescription is appropriate for the patient and that appropriate monitoring is in place. The pharmacy can demonstrate that they usually send a letter by email to a patient's regular GP detailing the patient's request. But there is insufficient evidence of good communication and shared care in the patients' best interests. This is because where no response is received from the GP within one day, the supplies are routinely made in any event primarily on the limited information derived from the patient questionnaire;

iii. make a clear record setting out their justification for prescribing, in circumstances where the patient does not have a GP or does not consent to share information".

88. On 21/11/2019 the practice manager at a GP surgery lodged a concern with the GPhC regarding UK Meds. The concern focused on a prescription for dihydrocodeine issued by UK Meds in the name of one of the surgery's registered patients. On inquiry, it emerged that the patient had not ordered the medication but that his daughter, Patient 7, who was an addict, had done so using the patient's name. The concern expressed the view that UK Meds *"practices and modus operandi appear flawed at best and dangerous at worst."* Some supplies of medication to Patient 7 are alleged to be linked to the Registrant. This concern became the subject of an investigation by the GPhC into UK Meds and was linked with the investigation concerning Patient 10.

89. Further regulatory activity was taken against UK Meds and individual pharmacists who had worked with UK Meds, including the Registrant.

90. On 6/9/2021, UK Meds stopped providing online prescribing services to patients.

91. It is right to record here that the GPhC's investigation of UK Meds was hindered by difficulties obtaining adequate disclosure of information from UK Meds, culminating in the GPhC having to obtain a Court Order to force disclosure in the first half of 2023. This is recorded here to explain, at least in part, the extended timetable in bringing this matter to a Principal Hearing. There is no suggestion that the Registrant was in any way responsible for the delays in obtaining disclosure from UK Meds.

92. Professional guidance relevant to this matter includes the following:

a. General Medical Council (GMC), 2013, Good practice in prescribing and managing medicines and devices;

b. Royal Pharmaceutical Society (RPS), 2016, A Competency Framework for all Prescribers;

c. General Pharmaceutical Council (GPhC), January 2018, Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet;

d. General Pharmaceutical Council (GPhC), April 2019, Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet;

e. General Pharmaceutical Council (GPhC), November 2019, In practice: Guidance for pharmacist prescribers.

It will be evident that some of the guidance listed above was in place substantially before the Registrant started work with UK Meds, one [(d) above] came into effect just before he started work with UK Meds, and the final one came into effect the month after he stopped working at UK Meds.

93. The factual particulars in the Allegation against the Registrant allege, in summary, that whilst working with UK Meds he:

a. Prescribed 7,684 prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring;

b. That in doing so he failed to follow relevant guidance, in particular, that he:

i. Relied on the patient Questionnaire completed by the patient;

ii. Failed to obtain adequate information in advance of prescribing;

iii. Failed to access or attempt to access GP or other clinical records relating to the patients;

iv. Failed to request face-to-face consultations with patients;

v. Failed to refer patients back to their GP for assessment, review, monitoring;

vi. Failed to put in place adequate safety-netting; and

vii. Failed to adequately consider the possibility of medication dependence and misuse.

c. Was prescribing when the UK Meds model was incapable of supporting safe prescribing decisions;

d. Was issuing prescriptions when the time taken would not have been sufficient to clinically evaluate the suitability of medicines;

e. Prescribed 100 tablets of dihydrocodeine 30mg to Patient 10 in circumstances when he had failed to take a number of steps including failing to attempt to access GP clinical records;

f. Prescribed high-risk medicines and/or medicines requiring ongoing monitoring when it was unsuitable to do so based on the patient Questionnaire completed by the patient;

g. Prescribed medicines to patients when he had failed to take a number of steps including failing to obtain adequate clinical information in advance;

h. That his approach to prescribing was transactional rather than in accordance with guidance.

94. The Registrant's case, in summary, was that he was and is a highly qualified pharmacist, qualified to issue prescriptions, and who issued prescriptions appropriately after undertaking reviews for each patient including clinical assessments, and in line with guidance, and did so at times quickly having developed

his own method of reviewing patient Questionnaires. There was no dispute that he worked with UK Meds as a pharmacist during the relevant period and that he issued prescriptions when he did so.

95. Elements of his case included:

a. That UK Meds was registered with the GPhC and he should be able to rely on that as a form of *"kite-mark"*;

b. That UK Meds had been the subject of inspections and, if the GPhC was so concerned with the operation of the pharmacy, it should have shut the pharmacy down rather than allow him to work with UK Meds leading to the allegations he now faces;

c. That he had, in any event, raised concerns with UK Meds about the operation of the pharmacy, concerns that focused on patient safety;

d. That he had complaints about the quality of the GPhC's investigation and the quality of the evidence presented by the GPhC against him, including having made a suggestion that he was directly implicated in the prescribing of medication associated with the death of a patient when this was clearly not the case as evidenced by material in the possession of the GPhC; and

e. To complain about the length of time between the facts alleged and the Principal Hearing (something over five years since he started at UK Meds), over which time his ability to work and personal well-being has been severely affected.

Stage 1: Decision on Facts

96. In reaching its decisions on facts, the committee considered the documentation listed at the start of this determination, oral evidence, the Registrant's statements made both when questioning witnesses and to present his case. The committee also took account of the submissions made on behalf of the GPhC and by the Registrant.

97. The committee accepted the advice of the Legal Adviser.

98. When considering each particular of allegation, the committee bore in mind that the burden of proof rests on the GPhC and that particulars are found proved based on the balance of probabilities. This means that particulars will be proved if the committee is satisfied that what is alleged is more likely than not to have happened.

99. Before reviewing the individual particulars, the committee records here observations and findings that are of generic value across the whole of the Allegation.

Ms 1 as an expert witness

100. A central part of the Registrant's case has been to question the expertise of Ms 1 as an expert witness called by the GPhC to give expert evidence including opinions in relation to this case.

101. He makes the point that she is a GP and not a Pharmacist nor Pharmacist Prescriber, has not functioned within an online setting, has worked in the public sector whereas the case is concerned with the private sector, and is based in Scotland not England with differing legal systems.

102. The committee accepted the advice of the Legal Adviser to the effect that it should consider whether:

a. Ms 1's evidence is relevant.

b. She has relevant experience;

c. She is impartial; and

d. She gives reliable evidence.

103. The committee concluded that it could place weight on Ms 1's evidence insofar as it relates to the principles of prescribing practice. It reached this conclusion for the following reasons.

104. The committee is satisfied that Ms 1's evidence is potentially relevant given that she has provided reports on the principles of prescribing practice including with regard to the medicines concerned with this case.

105. The committee is satisfied that she has relevant experience being a medical practitioner who has issued prescriptions, including with regard to the medicines involved in this case, and was aware of relevant law and guidance. The committee acknowledged that whilst she had experience of prescribing within traditional health settings, she did not have experience of prescribing in an online setting and that, in this respect, the committee would have to consider with care what weight it could attach to relevant parts of her evidence. The committee kept in mind that whilst her experience in traditional settings could provide insights as to the practice of prescribing online, this may not be as helpful for formulating opinions as if she had experience of working in an online setting. What is clear, however, is that there are principles of prescribing practice that are universal whatever the setting in which they are exercised.

106. The committee dismissed any concerns about her being based in Scotland and dismisses any concern regarding private-public sectors: there is a universality of the core principles involved with prescribing focused on patient safety, applicable across the UK and irrespective of whether prescribing occurs in the private or public health sectors. It is evident that she has familiarity with the principles and practice in England, and an awareness of relevant guidance applicable in the England. It is notable that the Royal Pharmaceutical Society (RPS) 2016 guidance referred to in this case is written explicitly to have *"applicability across the UK"*, was drafted with input from the Chief Phamaceutical Officers from all four home nations, including Scotland and England, and does not distinguish between private and NHS prescribing. That said, the committee bore in mind that she did not have experience of the private sector and that this might impact on the weight to be given to her evidence on how the universal principles may be put into practice in the private sector.

107. The committee took account of the Registrant's submissions that Ms 1 was in effect a *"hired gun"* and that she said what she was paid to say. The committee rejected this submission and was satisfied about her impartiality and that she understood her responsibilities as an expert witness, a role in which she had considerable experience across a number of tribunals.

108. The committee was similarly satisfied that her evidence was reliable. It was unhelpful that her report expressly referred to guidance that post-dated the events with which this case is concerned. The Registrant described this as a *"rookie mistake"* that a proficient expert would not have made, and which undermined the reliability of her evidence. The Registrant went further to argue that having referred to guidance post-dating events the reliability of her opinion was flawed by reason of *"unconscious bias"* that could adversely impact on her thinking and analysis. I.e. That when she came to assess the merits of his past behaviours she would unconsciously be assessing them against higher standards that came into effect at a later time. The committee did regard this aspect of her report (i.e. The express referencing of guidance post-dating events) as unhelpful, though the terms of her report appear to have been shaped by the terms of the instructions given to her by the GPhC. The committee was nevertheless satisfied that her opinions could be relied upon given the extensive referencing she made to guidance contemporaneous with events, in particular the RPS 2016 guidance. Nonetheless, the committee kept in mind the matters referred to in this paragraph when assessing the weight it could attach to the opinions she expressed.

109. Having considered some overarching issues above, the committee went on to consider the individual particulars in turn as follows.

Particular 1 (as amended – see above)

1. Between 20 May 2019 and 15 October 2019, you prescribed and/or approved at least 7,684 prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring.

110. The evidential trail for Particular 1 starts with disclosures made by UK Meds through their lawyers to the GPhC. The disclosures included 32 electronic spreadsheets, each reflecting the work of individual pharmacists who had worked with UK Meds including the Registrant. The spreadsheets recorded information regarding prescriptions issued by each pharmacist, including relevant dates, customer IDs, and items prescribed.

111. The evidence of Mr 1, Senior Data Analyst and Insight Manager at the GPhC, was that he then merged the separate spreadsheets to produce a single spreadsheet with all the data which he refers to as the "Combined List".

112. His evidence was that the GPhC's witness Ms 3 provided him with two categories of medicines, one for 'High-Risk Controlled Drugs' (Schedules 3, 4 and 5, such as dihydrocodeine) and 'High-Risk but Not Controlled Drugs' (such as amitriptyline) and listed named medicines within each category.

113. Mr 1's evidence was that he used these named drugs to conduct a search of the Combined List (of all pharmacists involved) to produce a spreadsheet "Combined List – High Risk".

114. Mr 1 gave evidence that he then removed individual customer names from the spreadsheets (leaving Customer ID numbers) to produce two electronic spreadsheets that he exhibited as:

    a. Exhibit SO1 – "Combined List – with Customer Name Removed"

    and

    b. Exhibit SO2 - "Combined List – High Risk - with Customer Name Removed"

115. Ms 3, a registered Pharmacist, gave evidence as to how she defined 'High-Risk' relying on:

    a. the British National Formulary ('BNF'),

    b. the Summary of Product Characteristics issued by manufacturers for individual medicines, and

    c. GPhC Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet guidance updated March 2022 (so post-dating the events leading to the Allegation) that lists medicines requiring additional safe-guards when dispensed through pharmacies providing services at a distance (such as UK Meds).

116. The GPhC 2022 guidelines included the following two categories of medicines:

a. Medicines liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important. For example, opioids, sedatives, laxatives, gabapentin, modafinil; and

b. Medicines that require ongoing monitoring or management. For example, medicines with a narrow therapeutic index, such as lithium and warfarin, as well as medicines used to treat diabetes, asthma, epilepsy and mental health conditions.

117. The committee notes that these two categories of drugs given in the GPhC 2022 guidance, closely match the two categories given in the GPhC's earlier guidance dated April 2019, issued just before the Registrant started work with UK Meds. The principal difference is in the first category (medicines liable to abuse etc) as follows:

a. pregabalin included in the 2019 guidance but which does not appear in the GPhC 2022 list, albeit pregabalin was then included in Ms 3's list of High Risk-Controlled Drugs and subsequently in Mr 1's analysis; and

b. modafinil which appears in the GPhC 2022 list as recited above but did not appear in the 2019 guidance, but which is then included in Ms 3's list of "High-Risk Not Controlled Drug".

118. The committee is satisfied that it is appropriate to include pregabalin as a high-risk drug for the purposes of this case as it was referenced by relevant guidance at the time of the events alleged against the Registrant. The committee was also satisfied that it was appropriate to include modafinil in the list of high-risk drugs given the terms of the BNF as issued for the relevant time (BNF 77 March – September 2019, provided to the hearing at the request of the committee) which includes advice that there should be pre-treatment screening using ECG, it has the *"possibility of dependence"* and carries a requirement to "*monitor blood pressure and heart rate in hypertensive patients"*.

119. Ms 3 produced her lists of High-Risk drugs in her exhibit NR/04 which was then used by Mr 1 to progress his work to produce the two spreadsheets.

120. Her exhibit NR/04 included a third category of medicines:

"Other drugs to consider not habit forming but may require ongoing monitoring and management where risks may be relevant depending person demographics, comorbidities, other drug interactions"

121. Ms 4, the GPhC's Lead Case Officer, gave evidence of how she was able to electronically manipulate the spreadsheet "Combined List – High Risk - with Customer Name Removed" to search for High-Risk medicines for which the Registrant (as opposed to any other pharmacist) had issued a prescription. According to her evidence, this process produced a list of 7,684 prescriptions for High-Risk medicines issued by the Registrant.

122. The committee found as follows:

a. It accepts the accuracy of the source data provided by UK Meds, produced as it was provided to the GPhC in circumstances when professional standards applied, provided under a Court Order, and provided through the legal representatives of UK Meds. The Registrant has not disputed that he issued prescriptions for drugs listed.

b. It is satisfied that the data has been stored and managed by the GPhC in a manner that ensures its integrity given the evidence of Ms 2, Mr 1 and Ms 4.

c. It is satisfied that Mr 1 has the appropriate skills and competency to have produced the two spreadsheets he exhibits.

d. It is satisfied that Ms 4 has the appropriate skills and competency to have produced the analysis she presents in her statements using the two spreadsheets exhibited by Mr 1

e. The Registrant accepts that he issued prescriptions for all the drugs listed in the Allegation and which then feature in the Exhibit NR/04.

f. The committee accepts Ms 4's figure of 7,684 prescriptions for High-Risk medicines issued by the Registrant.

123. The committee's conclusion on this issue is consistent with the Registrant's invoices to UK Meds for work done in September 2019 and October 2019. Indeed, the

Registrant relied on the numbers in Ms 4's analysis to some extent to highlight, in his submission, how carefully he had undertaken clinical assessments of patient Questionnaires to spot the fact that one patient Questionnaire was from a 10 year old and should not have got as far as a prescriber.

124. In reaching its conclusion on this issue, the committee had in mind that the number alleged (7,684) was less than the total number of prescriptions listed in Schedule A. However, this difference is largely accounted for by the fact that Particular 1 relates solely to High Risk medicines as defined for the purposes of this case whereas Schedule A is concerned with both High Risk medicines and in addition medicines requiring patient monitoring.

125. **Accordingly, the committee finds Particular 1 Proved, noting that it is drafted to read *"at least"* 7684 prescriptions.**

Particular 2

2. In relation to 1 above, you failed to prescribe medicines in accordance with and/or pay due regard to the relevant guidance on prescribing from the General Medical Council ("GMC"), the Royal Pharmaceutical Society ("RPS") and/or the General Pharmaceutical Council ("GPhC") in that you prescribed in circumstances where you:

2.1. failed to obtain adequate information in relation to the patients' health in advance of prescribing;

2.2. relied principally on the information received in an online questionnaire;

2.3. failed to access and/or attempt to access patients' General Practitioner ("GP") medical records and/or specialist clinic records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

2.4. failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication;

2.5. failed to adequately consider the possibility of medication dependence and misuse;

2.6. failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring; and/or

2.7. failed to put adequate safety-netting in place.

126. The committee understood from the terms of Particular 2 that it is set within the context of Particular 1 which is, in turn, concerned with those medicines identified as being high-risk and/or requiring ongoing monitoring.

127. Particular 2 refers to guidance in general terms (i.e. 'guidance on prescribing from the GMC, RPS and GPhC') without being more specific. The Skeleton Argument provided by the GPhC refers to four specific pieces of guidance relating to the GMC, RPS and GPhC in the context of Particular 2, namely:

a. General Medical Council (GMC), 2013, Good practice in prescribing and managing medicines and devices,

b. Royal Pharmaceutical Society (RPS), 2016, A Competency Framework for all Prescribers,

c. GPhC, April 2019, Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet, and

d. GPhC November 2019 "In practice: Guidance for pharmacist prescribers".

128. It will be immediately apparent that the fourth item of guidance listed above by the GPhC was issued after the Registrant had stopped working for UK Meds (15/10/2019). It cannot therefore be the case that he *"failed to prescribe medicines in accordance with and/or pay due regard to"* the November 2019 guidance when working at UK Meds. The committee has therefore had little to no regard to the

November 2019 guidance for the purposes of considering Particular 2. Insofar as it has had any regard to it, the committee makes this clear within the determination.

129. The remaining three items of guidance listed were applicable at the relevant time. In addition, the committee has had regard to GPhC January 2018 *"Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet"* that preceded the GPhC April 2019 guidance of the same title since the 2018 provides some context for the April 2019 guidance.

130. The committee went on to review the remaining three guidance documents referred to above as relevant to Particular 2.

131. **General Medical Council ("GMC") guidance:** the GPhC's main bundle of documentary evidence only includes the following GMC guidance:

"Good practice in prescribing and managing medicines and devices (2013)".

132. The committee took the view that this is not a primary source of information for Pharmacist Prescribers and therefore regarded it as having limited relevance for the purposes of considering Particular 2. It reached this conclusion given that it is issued by the GMC and is aimed at medical practitioners, not pharmacist prescribers. It is notable that the GPhC's witness Ms 3 (a pharmacist acting as a GPhC Senior Inspector at the time) does not refer to it in the context of her assessment of events. In addition, it is notable that it was not issued at the time the Registrant undertook his prescribing training in 2008, and pre-dated by several years the 2019 events with which this allegation is concerned. In that period between 2013 and 2019 other relevant guidance was issued, including the RPS guidance that is specifically about prescribing and is aimed at all prescribers, whether medical or pharmacist or otherwise.

133. It is perhaps significant that the GMC 2013 guidance gives guidance on prescribing without the prescriber having contact with the patient's GP. The GMC 2013 guidance is that in such circumstances prescriptions should not be issued. The later GPhC April 2019 guidance indicates that prescriptions may be issued provided a record justifying the prescription is kept. The difference between the two pieces of guidance suggests

that practices had changed over time rendering the GMC 2013 guidance less significant for the present case.

134. In summary, the committee has given limited weight to the GMC 2013 guidance for the purposes of this case. However, as the Registrant acknowledged, the principles in it are very much duplicated in other guidance including that of the RPS. The committee therefore concluded that the GMC 2013 guidance is of relevance and some assistance in its overall analysis.

135. **Royal Pharmaceutical Society ("RPS") guidance:** the GPhC's documentary evidence only includes the following RPS guidance:

"A Competency Framework for all Prescribers" dated July 2016.

136. It is notable that this guidance was in effect at the time of the facts alleged and that it was prepared by a multi-disciplinary project team, accredited by NICE and Health Education England. It provides a framework (update from earlier guidance) for *"all the prescribing professions in the UK"*. Accordingly, not only is this guidance produced by the professional body for Pharmacists it also reflects the universal competency framework applicable to all those who prescribe.

137. The committee concluded that this guidance was highly relevant to the case as a whole and specifically for the purposes of Particular 2.

138. **General Pharmaceutical Council ("GPhC") guidance:** the GPhC has produced a number of pieces of guidance (as distinct from Standards documents). The GPhC's evidential bundle produced for the purposes of proving its case had the following items of GPhC guidance.

139. GPhC, January 2018, Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet. (GPhC 2018 guidance). Not in force at the relevant time as it was replaced by guidance of the same title in April 2019. Whilst therefore not directly relevant, the GPhC 2018 guidance does provide some context and background to the GPhC April 2019 guidance that was directly relevant and in force at the time.

140. GPhC, April 2019, Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet. (GPhC April 2019 guidance). This came into force just before the Registrant started work at UK Meds and was in force throughout his time at UK Meds. It was issued by his regulatory body. It is aimed at pharmacy owners but includes references to the expectations on pharmacist prescribers.

141. The committee is satisfied that it is relevant to the case and consideration of Particular 2. The Registrant has said he was not aware of it at the time he started work at UK Meds (20/5/2019) but became aware of it at a later stage as a result of emails from managers at UK Meds. He argued that because it is aimed at pharmacy owners it did not show-up on searches he made. He questions the extent to which it was made available and suggests that if it was only sent to pharmacy owners he could not be expected to be aware of it.

142. The committee takes the view that he should have been aware of it: it is a document published by his regulatory body, shown to be available on the internet, and relevant to an area of work that he was becoming engaged (i.e. Prescribing in the context of an online pharmacy) and which was new to him. Whilst it is primarily addressed to the owners of online pharmacies, it also makes clear that all staff working at the pharmacy should be aware of it and apply it, and it does set out expectations placed on prescribers, not simply the owners of pharmacies. A diligent registrant would have made adequate inquiries to become aware of it.

143. When reviewing these documents, it is notable that whilst the GMC 2013 guidance reads:

> *"If the patient* [does not give consent for GP contact] *you should explain that you cannot prescribe for them…"*

the GPhC's April 2019 guidance (contemporaneous with events) provides more nuanced guidance in this respect indicating that prescriptions may be issued even when consent to contact a GP is refused but a record needs to be kept of the justification for prescribing.

It is also notable that the GPhC's November 2019 guidance (post-dating events) provides guidance that back-tracks closer to the original GMC by indicating that prescriptions may be issued in these circumstances but only in *"exceptional circumstances".*

144. The committee having concluded that the three guidance documents (GMC 2013, RPS 2016, and GPhC April 2019) have *"relevance"* for the purposes of considering Particular 2, the committee highlights the following extracts.

145. **General Medical Council (GMC), 2013, Good practice in prescribing and managing medicines and devices.**

For the reasons given above, the committee regards the GMC 2013 guidance as having only limited relevance to the case. However, as the Registrant observed during the hearing, the broad principles are consistent with later guidance.

It includes the following.

Highlighted in the summary on page 1 is guidance that reads:

> *"prescribe drugs…, including repeat prescriptions, only when you have adequate knowledge of the patient's health, and are satisfied that the drugs…serve the patient's needs."*

And

> *"check that the care or treatment you provide for each patient is compatible with any other treatments the patient is receiving…"*

And includes guidance on *"Sharing information with colleagues"*, including:

> *"30 You must contribute to the safe transfer of patients between healthcare providers and between health and social care providers. This means you must share all relevant information with colleagues involved in your patient's care within and outside the team…"*

And

"If you prescribe for a patient, but are not their general practitioner, you should check the completeness and accuracy of the information accompanying a referral. When an episode of care is completed, you must tell the patient's general practitioner about: (a) changes to the patient's medicines…"

And

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

And goes on to emphasise the importance of *"36…Effective communication…"* between those involved with the shared care of a patient.

And

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

And that

"53 Reviewing medicines will be particularly important where:… c) the patient is prescribed a controlled or other medicine that is commonly abused or misused d) the BNF or other authoritative clinical guidance recommends blood tests or other monitoring at regular intervals."

And

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

And, specifically in relation to remote prescribing, including online prescribing,

"60…you must satisfy yourself that you can make an adequate assessment, establish a dialogue…."

And

"61 You may prescribe only when you have adequate knowledge of the patient's health, and are satisfied that the medicines serve the patient's needs. You must consider: a) the limitations of the medium through which you are communicating with the patient b) the need for physical examination or other assessments c) whether you have access to the patient's medical records"

And

"64 If the patient has not been referred to you by their general practitioner, you do not have access to their medical records, and you have not previously provided them with face-to-face care, you must also:…c) follow the advice in paragraphs 30–34 on Sharing information with colleagues."

146. Key themes that therefore emerge from the GMC 2013 guidance are:

a. Prescribers are responsible for the prescriptions they issue, including repeat prescriptions,

b. Prescriptions should only be issued when safe and appropriate,

c. The prescriber must have adequate knowledge of the patient's circumstances, including their health and compatibility with other drugs taken,

d. The process may involve a dialogue with patients and physical examination, to enable the prescriber to have adequate information,

e. Prescribers should consider the reliability of the information given as part of the assessment of whether they have adequate information,

f. Particular care should be taken when considering controlled or other drugs commonly abused or misused,

g. Consent to contact the patient's GP should be sought and obtained when more information or confirmation of information is needed to justify a decision to prescribe,

h. Prescribers should ensure suitable arrangements are in place for monitoring, follow-up and review, and

i. Decisions to prescribe should be shared with other healthcare professionals involved with the patient.

These themes do then feature in the later guidance reviewed below.

147. **Royal Pharmaceutical Society (RPS), 2016, A Competency Framework for all Prescribers.**

This guidance is issued by the Registrant's own professional body. It is described as published to *"support all prescribers to prescribe effectively".* It refers to *"competencies"* as *"a combination of knowledge, skills, motives and personal traits"* which *"If acquired and maintained…will help healthcare professionals to be safe, effective prescribers who are able to support patients to get the best outcomes from their medicines."* It goes on to describe how the Competency Framework *"can be used by any prescriber at any point in their career to underpin professional responsibility for prescribing. It can also be used by regulators, education providers, professional organisations and specialist groups to inform standards,…".*

148. The guidance makes it clear that it is available on the internet.

149. The guidance emphasises the importance of *"professionalism"* and describes how this includes:

a. Always introduces self and role to the patient and carer.

b. Adapts consultations to meet the needs of different patients/carers (e.g. for language, age, capacity, physical or sensory impairments).

c. Undertakes the consultation in an appropriate setting taking account of confidentiality, consent, dignity and respect.

…

g. Recognises when safe systems are not in place to support prescribing and acts appropriately.

150. The guidance emphasises the importance of *"a patient centred approach"* delivered through an effective *"Consultation"* and supported by effective *"Prescribing governance".*

151. For 'Consultations', the guidance highlights the importance of:

a. 1:'Assess the Patient' including:

1.1 Takes an appropriate medical, social and medication history including allergies and intolerances.

1.2 Undertakes an appropriate clinical assessment.

1.3 Accesses and interprets all available and relevant patient records to ensure knowledge of the patient's management to date.

1.4 Requests and interprets relevant investigations necessary to inform treatment options.

1.5 Makes, confirms or understands, the working or final diagnosis by systematically considering the various possibilities (differential diagnosis).

1.6 Understands the condition(s) being treated, their natural progression and how to assess their severity, deterioration and anticipated response to treatment.

1.7 Reviews adherence to and effectiveness of current medicines.

b. 2: 'Consider the Options' including

2.7 Identifies, accesses, and uses reliable and validated sources of information and critically evaluates other information.

2.8 Stays up-to-date in own area of practice

c. 3: ‘Reach a Shared Decision’ including

3.4 Routinely assesses adherence in a non-judgemental way and understands the different reasons non-adherence can occur (intentional or non-intentional)…

d. 4: ‘Prescribe’ including

4.1 Prescribes a medicine only with adequate, up-to-date awareness of its actions, indications, dose, contraindications, interactions, cautions, and unwanted effects.

4.2 Understands the potential for adverse effects and takes steps to avoid/minimise, recognise and manage them.

4.3 Prescribes within relevant frameworks for medicines use as appropriate….

4.5 Understands and applies relevant national frameworks for medicines use…to own prescribing practice.

4.7 Considers the potential for misuse of medicines.

4.13 Communicates information about medicines and what they are being used for when sharing or transferring prescribing responsibilities/ information

e. 5: ‘Provide Information’ including

5.1 Checks the patient/carer’s understanding of and commitment to the patient’s management, monitoring and follow-up.

5.2 Gives the patient/carer clear, understandable and accessible information about their medicines (e.g. what it is for, how to use it, possible unwanted effects and how to report them, expected duration of treatment).

5.4 Ensures that the patient/carer knows what to do if there are any concerns about the management of their condition, if the condition deteriorates or if there is no improvement in a specific time frame.

f. 6: 'Monitor and Review' including

6.1 Establishes and maintains a plan for reviewing the patient's treatment.

6.2 Ensures that the effectiveness of treatment and potential unwanted effects are monitored.

6.4 Adapts the management plan in response to on-going monitoring and review of the patient's condition and preferences.

152. For 'Prescribing Governance', the RPS 2016 guidance highlights the importance of:

a. 7: 'Prescribe Safely' including

7.3 Identifies the potential risks associated with prescribing via remote media…and takes steps to minimise them.

7.4 Minimises risks to patients by using or developing processes that support safe prescribing particularly in areas of high risk (e.g. transfer of information about medicines, prescribing of repeat medicines).

b. 8: 'Prescribe Professionally' including

8.2 Accepts personal responsibility for prescribing and understands the legal and ethical implications.

8.3 Knows and works within legal and regulatory frameworks affecting prescribing practice (e.g. controlled drugs,…,regulators guidance,…).

c. 10: 'Prescribes as Part of a Team' including

10.1 Acts as part of a multidisciplinary team to ensure that continuity of care across care settings is developed and not compromised.

10.2 Establishes relationships with other professionals based on understanding, trust and respect for each other's roles in relation to prescribing

153. As set out above, for the purposes of this case, the committee regards the RPS guidance as very relevant and significant given that it is issued by the Registrant's own professional body, is aimed at Pharmacist Prescribers amongst others, had been issued some time before the 2019 events, and appears to be relatively comprehensive on the guidance it provides.

154. **GPhC, January 2018, Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet.**

This guidance is addressed to *"pharmacy owners"* responsible for pharmacies that provide pharmacy services at a distance, which would include UK Meds. Such pharmacy owners are identified as being *"responsible for making sure this guidance is followed"* though it goes on to state *"All staff have a responsibility to provide medicines safely to patients…"* which, given the terms of the guidance, would include the Registrant.

The guidance highlights (para.4.2) that *"Selling and supplying medicines at a distance including on the internet, brings different risks than those of 'traditional' pharmacy services"*, risks that should be considered and minimised. In this context, it highlights how pharmacy staff must *"get all the information they need from patients to check that the supply is safe and appropriate"* and that *"requests for medicines that are inappropriate, too large or too frequent"* are identified.

155. **GPhC, April 2019, Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet.**

As with the GPhC 2018 guidance, the GPhC April 2019 guidance is aimed at *"pharmacy owners"* operating remote pharmacy services including by way of the internet.

156. The GPhC 2019 guidance includes the following:

> *"Everyone in the pharmacy team, …, should understand the guidance and be aware of their responsibilities to follow it."*

The committee concludes that this includes the Registrant when working at UK Meds.

157. The guidance highlights that *"providing pharmacy services at a distance, especially online, carries particular risks which need to be managed".*

158. As with the GPhC 2018 guidance, the GPhC April 2019 guidance states that (para.4.2) *"Selling and supplying medicines at a distance including on the internet, brings different risks than those of 'traditional' pharmacy services"*, risks that should be considered and minimised. In this context, it highlights how pharmacy staff must *"get all the information they need from patients to check that the supply is safe and appropriate"* and that *"requests for medicines that are inappropriate, too large or too frequent"* are identified.

159. The guidance refers back to the GMC 2013 guidance to highlight that *"prescribers must prescribe drugs only when they: have adequate knowledge of the person's health, and are satisfied that the drugs serve the person's needs."*

160. However, unlike the GPhC 2018 guidance, the GPhC April 2019 guidance goes on (under section 4.2) to emphasise that prescribers must be:

> *"aware that some categories of medicines are not suitable to be supplied online unless further safeguards (see below for more details) have been put in place to make sure that they are clinically appropriate. The categories include:*
>
> - *….*
> - *Medicines liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important. For example opiates, sedatives, laxatives, pregabalin, gabapentin*
> - *Medicines that require ongoing monitoring or management. For example medicines with a narrow therapeutic index, such as lithium and warfarin, as well as medicines used to treat diabetes, asthma, epilepsy and mental health conditions"*
> - *….*

And it explains that *"medicines with a narrow therapeutic index"* are *"drugs with small differences between therapeutic and toxic doses."*

161. The guidance goes on to describe the safeguards that the pharmacy owner should be assured are in place if these categories of drugs are to be supplied online, as follows:

a. [identity checks – not relevant to the Allegation in this case],

b. the person has been asked for the contact details of their regular prescriber, such as their GP, and for their consent to contact them about the prescription,

c. you have assured yourself that the prescriber will proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP),

d. for medicines which are liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important, you have assured yourself that the prescriber has contacted the GP in advance of issuing a prescription, and that the GP has confirmed to the prescriber that the prescription is appropriate for the patient and that appropriate monitoring is in place,

e. if there are circumstances where the person does not have a regular prescriber such as a GP, or if there is no consent to share information, and the prescriber has decided to still issue a prescription, you should assure yourself that the prescriber has made a clear record setting out their justification for prescribing,

f. the prescriber is working within national prescribing guidelines for the UK and good practice guidance…..

162. Having reviewed the relevant guidance documents, the committee has gone on to consider the evidence in this case in the context of Particular 2.

163. The Registrant's case is that he was not aware of the GMC guidance, and that he had no recollection of his mentor referring to it. He stated to the committee that he would not have had access to it as it was GMC guidance and he is not a member of the GMC. On a number of occasions he accused the GMC and doctors of *"taking power to themselves"* by not being supportive of the Government's wish to see

pharmacists taking on a prescribing role. In short, he accused the medical profession of protectionism and with that view he referred to the GMC's guidance to state *"I'm not bound to follow that, a sectarian, union, approach. It's a self-interest rule"* albeit he also stated that he followed the principles in the GMC guidance since the GMC, RPS and GPhC guidance documents *"copy each other"*.

164. The committee noted that the GMC guidance is clearly marked as a publicly available document on the GMC website.

165. The Registrant stated that he was aware of the RPS *"from its inception"* and was *"familiar"* with it and that he followed the RPS guidance. He said in his statement to the committee:

> *"I followed the prescribing competency framework and I was satisfied in my head I did not prescribe outside of that framework."*

166. The committee refers again to the Registrant's awareness of the RPS guidance below.

167. The Registrant stated that the GPhC April 2019 guidance did not emerge from his due diligence research about the role of prescribing online. His explanation for not finding the GPhC April 2019 guidance was to say that it was probably because the guidance is aimed at pharmacy owners and not prescribers. He questioned when it was actually published. He suggested that it may only have been sent to pharmacy owners and that he could not therefore be expected to have known about it.

168. His case was that *"The first time I knew of it was when the Clinical Lead referred to it in an email"* and he referred the committee to an email in his evidence bundle from the Senior Clinical Lead within UK Meds dated 23/9/2019, which was a short time before he left UK Meds on 15/10/2019.

169. The committee did not accept his explanation. A diligent search for guidance relating to online prescribing, especially on the GPhC website, should have identified this guidance given that it relates to prescribing and prescribing online. Whilst it is aimed primarily at pharmacy owners it would, had he read it, have informed him what he should expect from UK Meds as well as the expectations placed on him as a prescriber. The committee was concerned that he was unaware of the GPhC April

2019 guidance for much of the time that he was prescribing at UK Meds given its significance to his role and the work he was undertaking at UK Meds.

170. The committee was left with considerable concerns regarding the Registrant's awareness of relevant guidance such as the GPhC 2018 or GPhC April 2019 guidance when prescribing at UK Meds.

171. When asked during committee questions after he had made a statement to the committee (as an alternative to sworn evidence) what guidance he relied on for his prescribing practice, his initial answer was to the following effect:

> *"A whole range of sources. For example, BMJ, various journals, whole lot of research and findings…It's not one thing. It's huge. Memes can give advice in concise forms. BNF gives information about drugs e.g. Asthma guidelines. Things like that are available. I tend to use NICE guidelines mostly, very comprehensive."*

172. The committee questioned him about this, pointing out that, for example, the NICE guidelines give clinical guidance rather than guidance around the prescribing process. He responded by saying *"I'm not sure what you mean."* Whilst being questioned, it was only when reminded of the RPS 2016 guidance on the prescribing process did he refer to his reliance on it. He stated *"Basically, what you are saying does not come to my mind because they are the fundamentals"*. He went on to describe his prescribing practise to involve *"welcome the patient, have good eye contact, ask them why they are here and tell them we'll solve it, make them relax, and give the patient the chance to express themselves"* and he went on to describe how he used a *"structured approach"* including a "systematic" assessment starting at the patient's head and proceeding to the toe. He concluded with *"It's a bit like asking someone how to drive. After some time it becomes ingrained."* It was the sort of guidance more relevant he said to a *"learner driving"* than himself who he compared to being a *"Formula 1 driver"* and as such consideration of the guidance by him went unsaid.

173. The committee was not convinced by his responses. It was concerned that the RPS 2016 guidance, which is the relevant guidance central to the work of all prescribers

at the relevant time, was not significantly in his mind when he was working at UK Meds. In addition, and as he conceded, at the time he worked at UK Meds the GPhC April 2019 guidance only came to his attention shortly before he left UK Meds.

174. The committee has taken account of the above review of the guidance when considering the Allegation as a whole.

175. The committee has considered each of the sub-particulars of Particular 2 in turn. However, it is apparent that they are closely interlinked.

Particular 2.1. alleges the Registrant failed to obtain adequate information in relation to the patients' health in advance of prescribing.

176. The committee considers this particular below after its consideration of Particulars 2.2 to 2.5.

Particular 2.2 alleges that the Registrant relied principally on the information received in an online questionnaire.

177. As a matter of fact, whilst the Registrant formally denied Particular 2.2, he accepted that his prescribing decisions relied principally on patients' answers to the patient Questionnaire. His case was that he also relied on his training, skills, knowledge and experience to analyse the information provided and to make risk-based decisions on whether or not to prescribe.

178. The committee accepts that the Registrant also had access to the UK Meds Patient Medical Records but in the main, these records are likely to have consisted of earlier completed patient Questionnaires for those patients who had previously ordered from UK Meds, along with records of any prescriptions previously issued or refused by UK Meds prescribers.

179. The committee also accepts the Registrant's statement that some patients might provide additional documents such as x-rays and medical letters.

180. Accordingly, in terms of *"information"* relied upon, it is clear that he was, in the main, relying on the answers provided by patients in the completed Questionnaires. He did not ordinarily have access to secondary sources of information such as might be gained through his own experience of seeing the patient face-to-face or through accessing GP records.

181. The requirement of the RPS 2016 and GPhC April 2019 guidance for prescribers to have adequate information (RPS *"appropriate"*, GPhC *"all"*), and requires prescribers to consider the reliability of the information that is available: adequate information would, of necessity, have to be adequate reliable information.

182. The committee finds that the answers given by patients on Questionnaires cannot be regarded as being wholly reliable for the purposes of prescribing high-risk drugs and/or drugs requiring ongoing monitoring. Even with the best will, patients cannot be relied upon to be comprehensive or accurate narrators of their medical history in the answers provided. Patients are not generally clinicians. Patients, even when trying their best, may forget or mis-recall or misunderstand medical details regarding their medical history including blood tests, diagnosis and treatments. It is also possible that patients may not be comprehensive, leaving out circumstances that they do not believe to be relevant when in fact they may be relevant to a clinician. Moreover, patients may be misusing, abusing or addicted to drugs and may therefore actively give answers that are incorrect or incomplete or misleading.

183. Without a two-way dialogue, clinicians would not be able to tease out from a self-completed patient Questionnaire additional information needed to inform clinical decisions including prescribing decisions.

184. In addition, without a reliable secondary source of information, patient answers would need to be regarded as unverified and their reliability in issue.

185. The committee finds that when prescribing high-risk drugs and/or drugs requiring ongoing monitoring, it would generally be inappropriate to rely on the answers given by patients in self-completed patient Questionnaires when the information given is unverified.

186. **Accordingly, the committee finds Allegation 2.2 proved.**

Particular 2.3 alleges that the Registrant failed to access and/or attempt to access patients' General Practitioner ("GP") medical records and/or specialist clinic records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

187. The RPS 2016 guidance under *"1. Assess The Patient"* specifically refers to the need to assess and interpret *"all available and relevant"* patient records.

188. The GPhC April 2019 guidance refers (under section 4.2) to the need for pharmacy staff *"get all the information they need from people receiving pharmacy services".* The guidance goes on to state that in respect of high-risk medicines and medicines requiring ongoing monitoring (i.e. Medicines within Particular 1) that additional safe-guards are required when prescribing online, including that patients should be:

> *"asked for the contact details of their regular prescriber, such as their GP, and for their consent to contact them about the prescription."*

189. The GPhC April 2019 guidance continues by requiring pharmacy owners to have:

> *"assured yourself that the prescriber has contacted the GP in advance of issuing a prescription, and that the GP has confirmed to the prescriber that the prescription is appropriate for the patient"*

And

> *"if there are circumstances where the person does not have a regular prescriber such as a GP, or if there is no consent to share information, and the prescriber has decided to still issue a prescription, you should assure yourself*

that the prescriber has made a clear record setting out their justification for prescribing".

190. Ms 1 expresses the opinion that access to patient clinical records is *"vital"*. Ms 1 states *"In my opinion, if a patient refuses to give these details, then notes cannot be accessed, and no medication can be safely prescribed without a face to face assessment."*

191. By his own account, the Registrant was not accessing or seeking to access GP records. On his account, he was entitled to rely on patient answers to the Questionnaire and that this was sufficient for him to make a prescribing decision when he did issue a prescription. He described the UK Meds patient Questionnaire as *"very comprehensive and very thorough"* albeit he also referred to the patient Questionnaire changing and improved over time. He told the committee that it was not part of his role to contact GPs and this was the role of the Clinical Lead.

192. His account was that when he thought access to GP records was required, he would either refuse to prescribe or refer an order to the Clinical Lead. The committee accepts that he may well have done so in some cases. What is apparent and uncontested however, is that on many occasions he issued prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring without seeking or having access to GP or other clinical records.

193. The value of having such access is demonstrated in the context of Patient 10 referred to below (Particular 5).

194. The documents available to the committee include an email sent by the Senior Clinical Lead at UK Meds to senior managers at UK Meds and which appears to be addressed to the prescribers working for UK Meds. The email refers to *"the latest GPhC guidance"* and provides a quotation from the guidance: the quotation and context appears to refer to the GPhC's April 2019 guidance. The email highlights that even when patient consent to contact their GP is refused, a *"prescription may still be issued as long as you consider it clinically appropriate and safe and can justify your reason"* and that a record needs to be made. The email continues by providing the prescribers a *"draft justification"* that could be used as a record in such

circumstances. The draft justification reads *"No consent has been given to contact the GP but the prescription requested is clinically appropriate and safe and has therefore been approved."* The email does not include advice on adapting the draft justification or adding to it any patient-specific reasoning.

195. The email underscores the working model at UK Meds, that prescriptions were, in the main, to be issued without seeking access to GP or other medical records.

196. The GPhC guidance referred to in the email is dated April 2019; the email is dated 23/9/2019, just a short time before the Registrant stopped working for UK Meds.

197. The committee is satisfied that the Registrant was under a professional obligation to ensure that before he issued a prescription for high-risk medicines and/or medicines requiring ongoing monitoring patients were asked for the contact details of their GP and their consent for the GP to be contacted by UK Meds *"about the prescription"*.

198. It appears that patients using the UK Meds were indeed asked for their consent for UK Meds to contact the patient's GPs over the time that he was working for UK Meds starting in April 2019. This appears from the copy patient Questionnaires that the committee has available, and also from the analysis of the UK Meds data undertaken by Ms 4 recorded in her statement (for example, under the heading "Multiple Supplies").

199. The committee is satisfied that the Registrant issued prescriptions for high-risk drugs and/or drugs requiring ongoing monitoring on many occasions when consent to contact the GP was refused and also when consent to contact the GP was given but in fact no effort was made by the Registrant for the GP to be contacted (for example, by referring the patient's Questionnaire to the Clinical Lead).

200. The committee has seen no record by the Registrant providing a justification for prescribing in these circumstances. He has not described recording a justification. The absence of records providing a justification for prescribing may well be explained by the fact that, on his evidence, he was unaware for most of his time at UK Meds of the GPhC April 2019 guidance requiring him to record a justification.

201. The committee accepted that the GPhC April 2019 guidance and the opinion of Ms 1 appear to conflict. The GPhC April 2019 guidance indicates that prescriptions for high-risk medicines may be issued even when there is no contact with the patient's GP provided a record is made setting out the justification for prescribing. Ms 1 expresses the opinion that "*if a patient refuses to give these* [GP] *details, then notes cannot be accessed, and no medication can be safely prescribed without a face to face assessment.*" The contrast is due to Ms 1 having regard to her professional guidance in the GMC 2013 document, whereas the GPhC April 2019 guidance is aimed at pharmacy owners and is applicable to pharmacist online prescribers. However, the committee is satisfied that the content, context and tone of the GPhC April 2019 guidance is clear, namely that a pharmacist prescribing high-risk medication without access to GP records would be an exceptional course to adopt. The committee is satisfied that this was implicit in the GPhC April 2019 guidance, for example by requiring a justification to be recorded and this was then made explicit in the GPhC November 2019 guidance.

202. In any event, the committee is satisfied that the circumstances in which the Registrant was working did not demonstrate exceptional circumstances to justify prescribing high-risk medication without access to GP records. Without GP records, the Registrant was unable to verify or otherwise ensure he had adequate reliable information to make a safe prescribing decision. In many instances, he was dealing with repeat prescriptions and patient's reporting chronic conditions. Patient 10 (referred to below) is a good example in this regard. The Registrant has not described circumstances that the committee could find to be exceptional to justify prescribing without access to GP records, such as in an emergency situation.

203. Without access to GP records the Registrant was unable to confirm, clarify or add to the information given by the patient. He was relying wholly, as he has said, on the truthfulness of the patient's answers. Without that fuller and more confident understanding of a patient's health the Registrant's ability to prescribe in a safe and appropriate manner was undermined.

204. **The committee finds Allegation 2.3 proved.**

Particular 2.4 alleges that the Registrant failed to request a face-to-face consultation with patients in order to adequately examine the clinical need for medication.

205. The RPS 2016 guidance envisages consultations involving a two-way dialogue between patient and prescriber. Under the heading *"Professionalism"* it expects prescribers to *"Always introduce self and role to the patient"*, to *"Adapt consultations to meet the needs of different patients"* and to undertake *"consultations in appropriate settings"*. Under the heading *"3. Reach a Shared Decision"* the RPS 2016 guidance expects prescribers to work with patients to make informed choices, to explain the rational, risks and benefits of treatment options in a way the patient will understand, and in a way that the prescriber *"Builds a relationship which encourages appropriate prescribing and not the expectation that a prescription will be supplied"*, and which explores the patient's understanding of the consultation.

206. The GPhC April 2019 guidance does not appear to reference the nature of the consultation process beyond setting a requirement that prescribers should "*get all the information they need from people receiving pharmacy services online so they can check that the supply of drugs is safe and appropriate"*, and that the additional safe-guards are in place when prescribing high-risk drugs and drugs requiring ongoing monitoring.

207. Ms 1 describes how in her opinion a *"two-way dialogue"* is a necessary part of a consultation process. Ms 1 states *"In my opinion, prescribing from a questionnaire without a face to face consultation is not and cannot be in a patient's best interests as the prescriber does not have a full and complete clinical picture of the patient, only self-reported information. Therefore, the prescriber cannot assess the patient clinically, assess their emotional and mental health or have any kind of meaningful therapeutic dialogue with them. There cannot, without some kind of face to face consultation, (which could be by video link), in my opinion, be informed consent on proposed treatment.*"

208. The Registrant denied this allegation. His case was that he *"could clinically assess patients without a face-to-face consultation"*. He described how *"face-to-face was redundant at UK Meds"*, that the patient Questionnaire used by UK Meds was *"very comprehensive and very thorough"* and because of this the information from the patient Questionnaires was sufficient to make prescribing decisions.

209. He described how in the GP practice setting where he met patients face-to-face he would examine patients starting at the head and working down their bodies. He went on to describe how he adapted this practice to his work in the online setting with UK Meds. He described how it was his practice at UK Meds to use the information from the patient Questionnaire to build a picture of the patient: he described how he could *"project an image of the patient onto a* [imaginary] *screen in front of me"* and compared this to as if a *"hologram"* of the patient was before him and how that enabled him to undertake a head-to-toe examination of patients on the answers provided by patients in the patient Questionnaire. He described himself to the committee as being like *"a cyborg"*.

210. In the context of high-risk habit-forming drugs, he stated that seeing a patient would add nothing because patients could hide their addiction.

211. In addition, the Registrant stated that seeing patients was not important: what mattered was the assessment of their histories looking for significant changes over time and for evidence of compliance with medication regimes.

212. The Registrant stated that if he concluded a face-to-face consultation was required before making a prescribing decision, he could either refuse the order or refer the patient to the Clinical Lead.

213. The committee accepts that on occasions he may well have refused a patient order and referred patient orders to the Clinical Lead on occasions when he concluded that he could not issue a prescription without a face-to-face consultation.

214. However, it is apparent from his own statements and from the evidence produced by the GPhC that the Registrant issued many prescriptions for high-risk medicines and

medicines requiring ongoing monitoring without having a face-to-face consultation with the patient.

215. On his own account the patient Questionnaire was imperfect, evolving and being refined over time. In any event, without a face-to-face consultation he was relying primarily on the written answers provided by patients on the Questionnaires, answers which, the committee finds, could not be sufficiently relied upon to be comprehensive and accurate, but which required a degree of professional scepticism and inquiry. The committee was not assured that the information from the patient Questionnaire would be sufficient to substitute for a face-to-face consultation with a patient, no matter how good a *"hologram"* the Registrant might envisage. He would not be able to assess the tone of voice or level of understanding of the patient. He would not be able to detect signs of substance misuse when visible, as they can be with some patients. He would not be able to physically examine patients, for example by assessing the location and degree of pain. He would not be able to ask questions or seek clarification of answers given. He would not be able to check heart rate and blood pressure or to take blood samples.

216. The committee concludes that in the absence of a two-way dialogue, in particular by way of a face-to-face consultation in cases involving high-risks drugs and/or drugs requiring monitoring, it would, ordinarily, be difficult to achieve the expectations of the RPS 2016 guidance given the limitations that must be placed on the comprehensiveness and reliability of patient Questionnaire answers.

217. The RPS 2016 guidance refers to the clinical assessment including an understanding of the patient's social history as well as medical history. A patient's regular GP, who has seen the patient on previous occasions, is likely to know something of their social and personal background, and would have access to medical records. A GP with that experience and access to medical records may, on occasions when the need arises be able to make clinical decisions without seeing the patient face-to-face, but the Registrant was in a very different position. The Registrant was not seeing evidence of previous prescriptions other than those that may have been issued by UK Meds. The patient Questionnaires seen by the committee have very limited questions relating to a patients' social circumstances. The Registrant was not privy to medical records

from reliable sources such as GPs and was not aware of anyone at UK Meds having had face-to-face consultations with patients yet went on to issue prescriptions for high-risk drugs and/or drugs requiring ongoing monitoring.

218. The committee is satisfied that in circumstances when he was issuing prescriptions for high-risk medication and/or medication requiring ongoing monitoring, he was under an obligation and a duty of care to have had a face-to-face consultation with patients to enable safe and appropriate prescribing decisions but failed to do so.

219. **Accordingly, the committee finds Allegation 2.4 proved.**

Particular 2.5 alleges the Registrant failed to adequately consider the possibility of medication dependence and misuse.

220. The RPS 2016 guidance to prescribers includes the requirement that prescribers will *"4.7 Considers the potential for misuse of medicines."* The Registrant was under a professional obligation to consider this and to do so effectively.

221. Ms 1's report highlights the importance of considering the risk that patients have a dependence on medication. She highlights the importance of:

a. prescribers asking themselves why patients are requesting medication from a costly online source rather than from their community prescriber with a cheaper NHS prescription charge,
b. prescribers asking themselves questions concerning dependence that might be prompted when patients refuse consent to contact their GP,
c. the value of face-to-face consultations to identify addiction issues by being able to see and listen to patients, and
d. the value of having access to past medical records to identify past or current addiction issues.

222. Ms 1's report includes the following:

"In my opinion, a prescriber [in the Registrant's position] *has no way of knowing why a medication has been requested, if there are underlying addiction or mental health issues and if it is still being supplied by their GP. There is no discussion with the patient to determine their knowledge of the medication, their clinical presentation or any addiction issues. In my opinion, without assessing and examining the patient face to face, the prescriber cannot be aware of the patient's current clinical condition and their current need for opiates. If a patient is requesting opiates for the purposes of diversion of misuse, without a face to face assessment and a discussion with the patient, the prescriber only has the self-reported questionnaire to rely on. Therefore, in my opinion, without access to the medical records, opiates should not be prescribed."*

223. The Registrant accepted that he was prescribing high-risk habit-forming drugs without face-to-face consultations, without access to medical records and, in some instances, when consent to access the GP was refused, as evidenced in the documentation.

224. The Registrant's case was that he did consider the possibility of medication dependence and misuse but that when he prescribed he had concluded the risks arising from prescribing outweighed the risks of not prescribing including in cases when he suspected patients might be addicted and the difficulties they would have with withdrawing if not supplied with drugs.

225. He also stated that in appropriate cases he issued prescriptions with reduced dosage as part of a treatment plan to ween patients off the medication over time.

226. In his statements to the committee, he observed that there may be legitimate reasons why patients would pay privately such as convenience, but without him also acknowledging that paying privately has the potential for hiding addiction.

227. The committee was concerned that whilst he may have considered dependence issues in some cases, perhaps when he refused or referred patients to the Clinical

Lead, he did not do so adequately in all cases when issuing prescriptions for high-risk medication that carried the risk of dependence, misuse and abuse.

228. The committee was not satisfied that the evidence showed he was putting patients onto effective treatment plans to reduce or address dependence. It was unclear how he could, from the self-completed patient Questionnaire and any UK Meds records, have diagnosed addiction or dependence. The committee finds that it is unlikely that a patient who is addicted to/misusing medication is going to declare this in the answers given in the patient Questionnaire. The UK Meds system allocated completed patient Questionnaires randomly to the UK Meds prescribers. In any event, a treatment plan depends on continuity of care: yet continuity of care was undermined by the fact the Registrant could not be assured the patient would return to UK Meds and, if they did submit another Questionnaire, there was no way of ensuring he would be the prescriber who considered it. Continuity of care might be achieved by making notes on the UK Meds Patients Medical Record, but the committee has seen no such notes. The records available to the committee do not show that the Registrant was agreeing with the patient a treatment plan to gain their consent to what he proposed. In addition, there is only limited evidence that he was prescribing medication at reducing dosages.

229. The committee's concerns are highlighted by reference to Patient 10.

230. The records for Patient 10 for example, show that Patient 10 was prescribed dihydrocodeine on sixteen occasions between April 2017 and May 2019, involving seven separate UK Meds prescribers,

231. The Registrant was responsible for issuing the final, sixteenth, prescription on 23/5/2019. There was no reduction in dosage between any of the prescriptions despite the label that warned of addiction and that the drug was for short term use only.

232. On the first fourteen occasions, Patient 10 was not asked to give consent for their GP to be contacted – the UK Meds process did not provide for the question to be asked at that time. On each of the last two occasions, including the last occasion the Registrant was responsible for, UK Meds processes did ask for consent. Patient 10 refused consent for their GP to be contacted. This meant that the GP was not contacted, no GP medical records were seen by the Registrant, and no notification would be sent by UK Meds to the GP advising that a prescription was issued that may have prompted a follow-up review or monitoring by the GP. Nonetheless, the Registrant went on to issue the final prescriptions for dihydrocodeine, an opiate based painkiller.

233. On 5/7/2019, a community pharmacist who had Patient 10 as a service user, registered a concern with the GPhC, expressing concern that UK Meds could, on the basis of a patient Questionnaire issue a prescription for an opioid painkiller to a patient, Patient 10, who was addicted to opioids and to do so on multiple occasions without informing the patient's GP. The community pharmacist expresses the view that this amounted to *"unprofessional conduct"*. The concern of the pharmacist is set out as follows:

> *"A patient who is seeking to obtain Dihydrocodeine is able to use google search terms 'buy Dihydrocodeine online' and be directed to a website allowing the direct selection of an opioid painkiller. They then can fill in a short questionnaire and be sent a large supply of medication which they are addicted to. The company do not inform the patient's regular GP and this supply can be made multiple times (more than 10). That a pharmacy would knowingly and repeatably supply these medications I think is unprofessional conduct."*

234. The pharmacist records that harm was caused and reports *"Patient became increasingly dependent on Dihydrocodeine, culminating in emergency hospital admission. Now under treatment of addiction centre."*

235. The pharmacist's registered concern led to a GPhC investigation. As a result, the committee now has a copy of Patient 10's medical record. It shows that Patient 10 had poor mental health and other conditions, and was under the care of healthcare professionals who saw her face-to-face. It also shows that on 28/5/2019, just days after the Registrant had issued her with a prescription for dihydrocodeine, she was subject to an emergency attendance at a hospital after reporting to her GP that she was suffering with withdrawal symptoms and had disclosed that she had been taking *"up to 700mg Dihydrocodeine daily, getting … dose from us* [the GP clinic] *then ordering over the internet as well"*.

236. The committee also has a copy of a letter dated 29/5/2019 written by Patient 10's GP to a local specialist drug misuse service. The letter makes it clear the GP has seen Patient 10 face-to-face: the letter refers to having *"a long discussion with Patient 10 about the fact that her medication is causing her more harm than good"* and describes how she has *"an unusual facial tremor"*. The letter lists eight different drugs that Patient 10 was prescribed by the GP. Plainly, this contrasts with the Registrant's position in that he did not see her, did not see her *"unusual facial tremor"*, did not speak with her and was unaware of the full list of drugs she was prescribed or her medical history beyond that which Patient 10 described in her completed patient Questionnaires.

237. The letter also discloses that on 28/5/2019, just days after the Registrant issued a prescription to Patient 10, the GP prescribed her dihydrocodeine. In his statements to the committee, the Registrant was critical of the GP issuing that prescription to Patient 10 when he, the Registrant, had prescribed Patient 10 dihydrocodeine just days before. To the committee, the Registrant argued that the GP should have checked what Patient 10 had been prescribed. When asked how a GP could reliably know whether or not a patient had been issued a prescription by an online pharmacy when (a) patients cannot be relied upon to disclose this and (b) UK Meds did not inform the GP, the Registrant had no substantive answer. The Registrant was asked that if he thought the GP should have checked what prescriptions Patient 10 had had from online sources, did he not also think that he, the Registrant, should have

checked what prescriptions Patient 10 had had from her GP. Again, he had no substantive answer. When asked if he should not have prescribed when he did not have a face-to-face consultation with Patient 10 nor her clinical records, he did not have any substantive answer. His focus was to criticise the GP and that he had only just started at UK Meds.

238. The committee concluded that by prescribing without a face-to-face consultation, for example with Patient 10, in conjunction with not having access to medical history, he failed to comply with the RPS 2016 and GPhC April 2019 guidance to adequately consider the possibility of dependence/misuse when he issued a prescription for high-risk medication.

239. The committee concluded that insofar as the Registrant may have considered issues about dependence and misuse when issuing prescriptions for high-risk medication, he did not do so adequately given that he was issuing the prescriptions without engaging in a two-way dialogue with patients and without reviewing their clinical records and without engaging with their GP or other treating clinician.

240. **Accordingly, the committee finds Allegation 2.5 proved.**

241. The committee has then returned to consider Particular 2.1.

Particular 2.1. alleges the Registrant failed to obtain adequate information in relation to the patients' health in advance of prescribing.

242. The need to obtain adequate information is referred to in the guidance documents. The RPS 2016 guidance has a section on *"1. Assess the Patient"* and describes the need to take an appropriate medical, social and medication history, undertaking a clinical assessment and assessing *"available and relevant"* patient records. The GPhC April 2019 guidance refers to staff, such as the Registrant, having *"all the information they need"* to ensure *"safe and appropriate"* supply of drugs to patients.

243. The GPhC April 2019 guidance refers to prescribers having to have *"all the information they need"*.

244. Particular 2 as a whole is set in the context of Particular 1, namely instances when the Registrant has issued medicines that are high-risk and/or requiring ongoing monitoring.

245. The committee was therefore satisfied that he was under a professional obligation to obtain adequate information before prescribing and that this obligation was particularly significant when prescribing high-risk drugs or drugs requiring ongoing monitoring.

246. He has issued prescriptions primarily on the basis of information from one source, namely the patient requesting the medication on the basis of answers given in self-reported patient Questionnaires.

247. Having regard to Particulars 2.2, 2.3, 2.4 and 2.5, the committee has already found that he prescribed such drugs:

a. Relying on answers given by patients in the Questionnaires, answers that cannot be regarded as wholly reliable without being verified,

b. Failed to access GP records for medical information and verification of patient answers,

c. Failed to request face-to-face consultations to adequately examine the need for medication, and

d. Failed to consider the possibility of medication dependence and misuse.

248. Given these findings, the committee finds, with regard to Particular 2.1, that he failed to obtain adequate information in advance of prescribing.

249. The committee has further considered the evidence in relation to Particular 2.1 as follows.

250. The evidence of Ms 1 is that the Registrant could not have met the expectations of the RPS. Ms 1 refers to the need for *"two-way dialogue"* between patient and prescriber. Ms 1 expresses the opinion that *"it is only by speaking to the patient that*

a prescriber can determine underlying emotions, anxieties and current mind set of a patient, thereby adapting treatment options to the patients underlying condition and treatment goals." Ms 1 goes on to express the opinion that when there is no two-way dialogue but reliance is placed by the prescriber on the answers provided by a patient in the online questionnaire *"there is no corroboration of symptoms, no physical assessment, no confirmation of current or past health or medication prescribed"* and *"In my opinion, online prescribing from self-reported questionnaires is insufficient to enable safe and appropriate, evidence based prescribing."*

251. The Registrant's case was expressed in a letter he wrote to the GPhC Chief Executive and Registrar dated 3/12/2023 when he wrote:

> *"The Patient's answers to the Questionnaire, of necessity, had to be accepted as being truthful and having been provided in good faith."*

This reflected statements he made to the committee. It also references a section of the patient Questionnaire which required patients to agree to the terms and conditions of UK Meds in order to use UK Meds services including the following condition that required patients to confirm:

> *"You* [the patient] *have answered all the above questions accurately and truthfully You understand the prescriber will take your answers in good faith and base their prescribing decisions accordingly, and that incorrect information can be hazardous to your health."*

252. The committee takes the view that it is one thing for UK Meds to have put an onus on patients to answer questions *"accurately and truthfully",* but it is concerning to the committee that the Registrant concluded *"of necessity"* he then had to accept answers as truthful. His approach over-rides his professional responsibility to have an attitude of professional inquiry and apply appropriate professional scepticism, particularly when dealing with patients seeking drugs that may be subject to abuse and misuse. Further, his approach ignored the possibility that patients who, in good faith, believed that they were giving accurate and truthful answers could nonetheless be inaccurate or incomplete in the information that they gave.

253. His approach in this regard was consistent with his statements that the online pharmacy improved access to healthcare, and also that patient-centred care involved providing medication requested by a patient unless he identified a reason not to do so.

254. In the context of prescribing high-risk drugs and/or drugs requiring ongoing monitoring, the committee prefers the opinion of Ms 1 over that of the Registrant. Even with the best will, patients cannot be relied upon to be comprehensive or accurate narrators of their medical history. Patients are not generally clinicians. There is always the possibility that a patient trying their best may still forget or mis-recall or misunderstand medical details regarding their medical history including blood tests, diagnosis and treatments. It is also possible that patients may not be comprehensive, leaving out circumstances that they do not believe to be relevant when in fact they may be relevant to a clinician. Moreover, patients may be misusing, abusing or addicted to drugs and may therefore actively give incorrect or incomplete or misleading answers to the patient Questionnaire.

255. In the context of prescribing high-risk drugs and/or drugs requiring ongoing monitoring, the committee was satisfied that without the two-way dialogue referred to by Ms 1, and without access to clinical records, prescribers are likely not to have clinically adequate information.

256. Within the context of high-risk drugs and/or drugs requiring ongoing monitoring, the committee was satisfied that the Registrant was under a professional obligation to obtain adequate information before prescribing and that without a two-way dialogue with patients and/or access to clinical records he failed to obtain adequate information in advance of prescribing on those occasions when he prescribed high-risk drugs or drugs requiring ongoing monitoring.

257. **Accordingly, the committee finds Allegation 2.1 proved.**

Particular 2.6 alleges the Registrant failed to refer patients back to their GP for appropriate assessment and/or review and/or monitoring; and/or

258. The RPS 2016 guidance requires prescribers to:

"6: MONITOR AND REVIEW

6.1 Establishes and maintains a plan for reviewing the patient's treatment.

6.2 Ensures that the effectiveness of treatment and potential unwanted effects are monitored.

6.4 Adapts the management plan in response to on-going monitoring and review of the patient's condition and preferences."

259. The GPhC April 2019 guidance includes the following under the heading concerned with *"further safeguards"* required to be in place when prescribing medicines liable to abuse and medicines requiring ongoing monitoring or management:

"you have assured yourself that the prescriber will proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP)"

"for medicines which are liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important, you have assured yourself that the prescriber has contacted the GP in advance of issuing a prescription, and that the GP has confirmed to the prescriber that the prescription is appropriate for the patient and that appropriate monitoring is in place",

and

"if there are circumstances where the person does not have a regular prescriber such as a GP, or if there is no consent to share information, and the prescriber has decided to still issue a prescription, you should assure yourself

that the prescriber has made a clear record setting out their justification for prescribing"

260. Whilst the guidance is directed at pharmacy owners, it clearly sets out expectations on individual prescribers such as the Registrant and, as the committee has already found, he should have been aware of it.

261. The GPhC's evidence shows that on many cases, the Registrant issued prescriptions for high-risk drugs and/or drugs requiring ongoing monitoring, such as dihydrocodeine, without contacting the patient's GP in advance (even in cases when consent had been given, such as with Patient 10) and without then ensuring that the information about a prescription having been issued was then shared with the patient's GP.

262. There was no evidence that he made a record of his justification for prescribing without contacting the patent's GP. As he has admitted, he was unaware of the GPhC April 2019 guidance containing that requirement over much of his time at UK Meds, and only became aware of it when the Senior Clinical Lead emailed UK Meds prescribers in late September 2019, a copy of which the committee has seen.

263. His case went further to state that he could not have shared prescribing information with a patient's GP when consent had not been given because this would breach the patient's privacy and data protection laws. The Registrant did not acknowledge that his alternative decision in those cases was not to prescribe at all given the risks and concerns that arose when prescribing such drugs without contact with the patient's GP.

264. During his submission to the committee, the Registrant stated, *"If they are registered with a GP it's fair to say they are being monitored – GPs are paid to do monitoring".* This statement caused the committee concern and is additional evidence of his approach which did not place sufficient importance on relevant professional guidance and the responsibility that rested on him for every prescription issued. It is

a statement that assumes the patient is telling the truth that they have a GP even when they decline to give contact details and declined to give consent for their GP to be contacted. It assumes that the patient is accurately reporting their condition. It assumes the GP is aware of the condition. It assumes the GP will become aware of the need to monitor. It assumes the GP will then undertake monitoring. In the committee's assessment, the Registrant failed when he made these assumptions.

265. **Accordingly, the committee finds Allegation 2.6 proved.**

Particular 2.7 alleges the Registrant failed to put adequate safety-netting in place.

266. Ms 1's reports provide a definition of *"safety-netting"* as follows:

> *"Safety netting was defined as a consultation technique to communicate uncertainty, provide patient information on red-flag symptoms, and plan for future appointments to ensure timely reassessment of a patient's condition."*

267. The Registrant referred to a definition of safety-netting from the British Medical Journal (BMJ) which he summarised as 'a consultation technique used to manage clinical uncertainty'.

268. The RPS 2016 guidance provides the following:

> "5.1 Checks the patient/carer's understanding of and commitment to the *patient's management, monitoring and follow-up.*
>
> *5.2 Gives the patient/carer clear, understandable and accessible information about their medicines (e.g. what it is for, how to use it, possible unwanted effects and how to report them, expected duration of treatment).*
>
> *5.4 Ensures that the patient/carer knows what to do if there are any concerns about the management of their condition, if the condition deteriorates or if there is no improvement in a specific time frame."*

269. The GPhC April 2019 guidance provides the following under Principle 4 (which is concerned with safeguarding patient health, safety and wellbeing):

"make sure people receiving pharmacy services know who to contact if they have any questions or want to discuss something with the pharmacy staff"

And, under Principle 4.4 "Information for pharmacy users"

"You must give clear information to people who use your pharmacy services about how they can contact your pharmacy staff if they have any problems or need more advice. This should also include advice on when they should go back to their GP or local pharmacist."

Whilst this guidance is directed at pharmacy owners it clearly sets out expectations on individual prescribers such as the Registrant and, as the committee has already found, he should have been aware of it; he has accepted that he was not aware of the GPhC April 2019 guidance for much of the time he was working with UK Meds.

270. The GPhC's case was that by not having contact with patients, he failed to provide appropriate safety-netting.

271. The Registrant's case was that he put adequate safety-netting in place, relying on text he could add to the label placed on medication boxes sent to patients and also relying on the patient information leaflets contained within the boxes. He went on to state that *"Patients were clear about signs of failed treatment and …. patients were aware of the risk of addiction and signs of withdrawal such as shaking and sweating. Patients are aware of these symptoms through experience and previous use of medicines, the medication packaging and labels."*

272. The committee is clear that the guidance imposes a professional obligation on the Registrant when prescribing high-risk drugs and/or drugs requiring ongoing monitoring to ensure appropriate safety-netting is in place.

273. The committee accepted his evidence that he could type text onto the label attached to the medication sent to patients – he gave as an example the text he wrote on the medication label when he issued a prescription for dihydrocodeine to Patient 10 on 23/5/2019, as follows:

"Take ONE every six hours when required or as directed by your prescriber. DO NOT exceed 120mg daily. Short-term use only. This medication can cause addiction."

274. The committee notes that this replicates exactly text given by previous prescribers when prescribing dihydrocodeine to Patient 10 – see for example, prescriptions dated 25/4/2018, 25/6/2018, 30/8/3018, 10/1/2019, and 28/1/2019. In noting this, the committee observes that it appears the Registrant was simply copying what previous prescribers had written without undertaking his own independent review of Patient 10's request for medication, and that had he done so he may have either chosen to refuse the order or to write additional text on the label, for example, a requirement for consent to contact Patient 10's GP in the event of any future orders, something he says he did.

275. The committee accepts that the information on the label provides a degree of safety-netting but further concludes that it is inadequate given that he was reliant on the patient reading, understanding and following the explanatory leaflet accompanying the medication and the label on the medication box. However, there is no evidence he has put in place arrangements for future appointments and monitoring. Without a two-way dialogue with the patient and/or reassurance through contact with the patient's GP or GP notes, he could not be assured of the patient's level of understanding and commitment to managing their use of the drug. He also assumed patients would have medical knowledge of symptoms of addiction and symptoms of withdrawal. Given that the drugs fall within the high-risk category, the committee is not satisfied that it was adequate for him to rely on these assumptions. His approach in this regard was consistent with other statements made by him, including his understanding of patient centred practice involved prescribing the drug requested by the patient unless he identified a reason not to do so (instead of positively identifying a justification to prescribe). His approach was also consistent with his statement that *"of necessity"* he had to trust patients to provide accurate and comprehensive information and, in effect, trust patients to comply with a condition of engaging with UK Meds services to *"read the Patient Information Leaflet".*

276. **Accordingly, the committee finds Particular 2.7 proved.**

277. Whilst reviewing the evidence relating to Particular 2 (and other particulars) the committee has had in mind the Registrant's case that online patient questionnaires are currently used in other medical/health settings. He referred to the NHS 111 telephone line, Lloyds online pharmacy, and the NHS Out of Hours ('OOH') service. He provided examples taken from the internet of the Lloyds online questionnaire and an example of a questionnaire he had been required to use when working within an OOH service.

278. The committee acknowledges that questionnaires may well be used in healthcare settings. However, it notes that where questionnaires are used the issue of patient safety and the appropriateness of issuing prescriptions would in part depend on the degree to which healthcare professionals were able to have a two-way dialogue with patients, examine them, have access to patient medical records, and the degree to which the treatment proposed was in an emergency situation. NHS healthcare providers may well have access to a patient's NHS medical record, may be dealing with an emergency situation, and may well have a two-way dialogue with patients (face-to-face or by telephone when a patient may be required to attend a face-to-face consultation). In addition, when medication is prescribed without having access to medical records it may be on the basis of an emergency situation and when only the bare minimum of medication is prescribed to cover the period until a GP and/or medical records can be accessed. Finally, when care is given within a NHS setting such as NHS 111 or an OOH service, the consultation with a patient would always be followed up by a letter to the patient's GP to ensure continuity of care, including further assessment, review and safety-netting.

279. The committee concluded that it may be, as the Registrant has argued, that questionnaires can be used appropriately in healthcare settings but the committee has also concluded that the appropriateness of questionnaires is likely to be dependent on the prevailing situation. It is not for this committee to reach any firm conclusions in this regard in relation to other healthcare settings (NHS or otherwise). What the committee is required to do is to assess the appropriateness of the Registrant's prescribing practice whilst at UK Meds when he relied primarily on the

patient Questionnaires. The Registrant had three options when reviewing a patient Questionnaire: to Refuse the order, to refer the order to a Clinical Lead for review, or to Approve the order. As has been evidenced (and not disputed) the Registrant approved many prescriptions whilst at UK Meds. As indicated above, the committee finds that in the context of prescribing high-risk drugs and/or drugs requiring ongoing monitoring, his practice of approving prescriptions was not appropriate given that he failed in the ways set out in Particular 2.

280. **As recorded above, the committee finds the entirety of Particular 2 proved.**

Particular 3

3. In relation to 1 above, you prescribed in circumstances where the UK Meds Direct Ltd prescribing model or service was incapable of supporting safe prescribing decision in that:

3.1. no face-to-face consultation took place other than the use of a questionnaire;

3.2. patients were allowed to pre-select the medicine, strength, and quantity they desired;

3.3. patients provided information primarily through a questionnaire;

3.4. the questionnaire at 3.3 above could be easily manipulated by patients as it notified them of answers which could prevent the supply of the medication they desired and permit the patient to change their answer.

281. The context of Particular 3 is different from other allegations in that it alleges the Registrant prescribed in circumstances when the UK Meds prescribing model of operating was *"incapable of supporting safe prescribing decisions"*.

282. The detail of Particular 3 is similar to other particulars – e.g. 3.1 No face-to-face consultation and 3.3 reliance on Questionnaires – but also includes allegations that patients could pre-select their medication (3.2) and the possibility of patients

"manipulating" their answers to the patient Questionnaire to get the medication that they wanted (3.4).

283. The committee has already found that working within the UK Meds prescribing model the Registrant was able to prescribe primarily relying on the patient Questionnaires and without face-to-face consultations and without receiving adequate information including from GP records to inform safe prescribing. In prescribing in this manner, he was prescribing in line with the expectations of the UK Meds model.

284. To the extent that Particular 3.1 alleges face-to-face consultations did not take place, and Particular 3.3 alleges that patients primarily provided information through the patient Questionnaire, the committee has already found these as a matter of fact (see Particular 2 above) and does so again for the purposes of Particular 3.

285. The committee further finds as a fact that proof of Particulars 3.1 and 3.3 is proof of UK Meds prescribing model being incapable of supporting safe prescribing decisions. For the reasons already given, the committee rejects the Registrant's argument that he was able to prescribe safely and accepts the evidence of Ms 1 in her reports as a whole and as referred to above. The UK Meds prescribing model was an enabler: it mandated and positively encouraged the Registrant to prescribe in the way he did. It did not encourage face-to-face consultations and did not encourage prescribers to seek GP records. The UK Meds prescribing model expected prescribing decisions to be made primarily on the basis of patient Questionnaires alone.

286. Particular 3.2 alleges that the UK Meds prescribing model allowed patients to pre-select the medication they wanted. Evidence that this was factually the case is in the Inspection report of 3/9/2019. This report provides a snapshot of how UK Meds functioned at the time the Registrant was working there. The report reads:

> *"The pharmacy website allows people to select a medicine before a consultation."*

287. Particular 3.4 alleges that the UK Meds prescribing model allowed patients to manipulate the answers given in patient Questionnaires.

288. The Inspection report of 3/9/2019 reads:

> *"The customer was able to change their answers. If a person gave an answer which meant it was inappropriate for them to have the medicine, the following box appeared 'Based on the answer you've given us, it would be best for you to consult your GP or specialist. You are unable to continue.' The person could then change their answer, which then allowed for the supply of the medicine and they were able to continue with the purchase. The alteration was not auditable and did not flag to the prescriber or pharmacy."*

289. The GPhC April 2019 guidance, directed at pharmacy owners such as at UK Meds, requires, under Principal 3:

> *"the websites of companies you work with are arranged so that a person cannot choose a POM and its quantity before there has been an appropriate consultation with a prescriber. It should be made clear that the decisions about treatment are for both the prescriber and the person to jointly consider during the consultation."*

290. Ms 1's reports reviewed the UK Meds prescribing model. In short, her opinion was that *"the model used by UK Meds Ltd was unsafe"* and did not operate within the RPS 2016 guidance. She expands on this in her reports, including:

a. *"in my opinion, in order for a prescription to be authorised and for it to be in the patient's best interests (of any kind but particularly High Risk Medications) …. A Clinician must have a full clinical picture before it is safe to prescribe. This, in my opinion, will include access to medical records or discussion with the patient's GP, corroboration of symptoms and diagnoses given, via face to face assessment, and provision of adequate monitoring and follow up."*

b. *"In my opinion, without adequate medical records, clinical assessment, access to onward referral or monitoring, there cannot be adequate clinical review in an online setting."*

c. *"In conclusion, in my opinion, a PIP, prescribing for UK Meds Ltd, lacked the ability to Assess the Patient, Identify Evidence-Based Treatment Options for Clinical Decision Making, Present Options and Reach a Shared Decision, Prescribe, Provide Information, Monitor and Review, Prescribe Safely, Prescribe Professionally, Improve Prescribing Practice and Prescribe as Part of a Team. Therefore, in my opinion, a PIP could not safely prescribe high risk medications or for chronic diseases, nor were they able to diagnose medical conditions and initiate treatment from the information given in the self-populated questionnaire as they could not adhere to the requirements of the prescribing framework. The Company stated that their prescribers were not diagnosing, only prescribing a medication that the patient was already being prescribed. In practice, however, without accessing the medical notes or talking to the patient's GP, the prescriber was "diagnosing" conditions from the limited history given and then deciding if the requested medication was suitable for the stated condition."*

291. The Registrant has not significantly challenged either the fact that patients could pre-select medicines nor that they could change their answers. His case was that there was nothing inherently wrong with patients pre-selecting medication or changing their answers. He compared his position at UK Meds to a patient who attended at a community pharmacy asking for a specific medicine: there would be no guarantee they would be supplied with it and questions could be asked if appropriate before a decision to sell medication was made and, on being asked questions, patients could change their answers.

292. His case was that he exercised safe prescribing practices, that the patient Questionnaire was a *"means to and end"* for the purposes of making a prescribing decision and there was *"no guarantee or access to medication"* that the patient would get what they asked for. He stated *"patients could ask for a medicine but that didn't mean they could get it."*

293. The Registrant's case was that he was not aware of the GPhC April 2019 guidance which states that patients should not be able to pre-select a medicine and, in any event he had no difficulty with patients being able to pre-select their choice of medicine. The Registrant argued that within the UK Meds model he had a choice not to prescribe and alternatively to refer patients to the Clinical Lead if he was not satisfied it was safe to prescribe on the basis of the information he had.

294. In the committee's assessment, his comparison with a community pharmacy is flawed. Unlike the UK Meds online model, a community pharmacist would have face-to-face two-way dialogue with patients, the pharmacist would hear any changes to answers given, and be able to assess the patient's presentation and level of understanding to inform their decision to supply. These were not options available to the Registrant when he prescribed: he did not see patients; did not have a two-way dialogue with patients; and, according to the Inspection Report, would not be able to see any changes made to answer given in the patient Questionnaire, changes designed to get the medication sought.

295. Whilst the Registrant may have had, and used on some occasions, the options of refusing an order and referring a patient to the Clinical Lead, the evidence also shows that working within the UK Meds prescribing model the Registrant issued many prescriptions for high-risk drugs and/or drugs requiring ongoing monitoring when he would not have engaged with the patient nor had access to clinical records. The committee concludes that the UK Meds prescribing model enabled and encouraged the Registrant's approach to prescribing, which, as he described, was to prescribe unless he identified a reason not to do so; and his approach was in line with the UK Meds prescribing model that facilitated prescribing without complying with the GPhC April 2019 Guidance to pharmacy owners.

296. For reasons already given, the committee is satisfied that the Registrant should have been aware of the GPhC April 2019 guidance.

297. In these circumstances, the committee finds that the UK Meds prescribing model did not support safe prescribing decisions concerning high-risk drugs and/or drugs

requiring ongoing monitoring and it was a model within which he worked and prescribed high-risk drugs and/or drugs requiring ongoing monitoring.

298. In reaching these conclusions, the committee has taken account of the GPhC letter to UK Meds dated 12/6/2019, referred to by the Registrant in his statements and submissions to the committee. The GPhC 12/6/2019 letter came about in the following way:

a. Following concerns received by the GPhC from members of the public and healthcare professionals, the GPhC reviewed the operation of UK Meds.

b. On 29/3/2019, the GPhC issued a statutory *"Improvement Notice"*. This is a notice issued by the GPhC when it has significant concerns that a pharmacy is not meeting expected standards and patient safety is at risk. The Improvement Notice issued to UK Meds required UK Meds to strengthen procedures relevant to patient safety.

c. On 14/5/2019, (just days before the Registrant started work with UK Meds) GPhC inspectors undertook a *"follow-up visit"* to UK Meds.

d. The *"follow-up visit"* and other information provided by UK Meds to the GPhC led the GPhC to issue its letter of 12/6/2019. That letter reads: *"following a review of all the information you have provided in response to the Improvement Notice…, we believe you have now met the minimum standards to satisfy the Improvement Notice".*

299. The Registrant described this as a *"Good to go"* letter, evidence that the UK Meds prescribing model was regarded as safe by the GPhC and that this reflects the model that he functioned in whilst working with UK Meds.

300. His argument is consistent with his earlier arguments that before joining UK Meds he undertook a due diligence check on UK Meds, including being reassured by UK Meds that it was registered with the GPhC, had passed an inspection and was working with the GPhC to enhance its systems. He refers to the GPhC Inspection Report on UK Meds following an inspection on 15/2/2018 (over a year earlier at a time when the GPhC April 2019 guidance to pharmacy owners had not been issued, though earlier

guidance of January 2018 was in place) that found the UK Meds pharmacy service *"Satisfactory"* across all the areas inspected.

301. The Registrant repeatedly expressed his sense of injustice at being held to account by the GPhC for working with UK Meds over a time when the GPhC had registered UK Meds as a pharmacy, held it to be operating in a *"Satisfactory"* manner, allowed it to use the GPhC logo which he regarded as a "kite-mark" of quality, and was closely engaging with UK Meds over the time that he worked there. His submission was that if he is supposed to have realised it was not operating safely then the GPhC should also have done so and the GPhC had the enforcement powers to stop UK Meds operating but did not do so while he worked there. He places a significant amount of responsibility on the GPhC for causing him to have worked at UK Meds and now to be accused of misconduct.

302. The committee acknowledges that it has some sympathy with the Registrant's submission in this regard. The GPhC was aware that the UK Meds prescribing model was based on the use of a self-reporting patient Questionnaire, knew that the high-risk drugs were being prescribed and dispensed in significant quantities, knew that patients could choose their medicines and could change their answers without this being visible to prescribers, along with other concerns identified by the GPhC (see for example the 2018 Inspection Report, the notes of the follow-up visit on 14/5/2019 and the GPhC letter of 12/6/2019).

303. However, the following should also be noted:

a. The remit of the committee is to review the fitness to practise of the Registrant, not to review the quality of the GPhC's inspection and enforcement work.

b. The committee is not bound by the GPhC's 2018 inspection finding of *"Satisfactory"* nor the GPhC 12/6/2019 letter that UK Meds *"met the minimum requirements to satisfy the Improvement Notice"*. The committee does not have all the inspection material available to the GPhC. It is for the committee to exercise its own judgement and reach its own independent decisions based on the material it has.

c. In any event, the GPhC 12/6/2019 letter identified continuing concerns with the UK Meds prescribing model – the letter did not give UK Meds a 'clean bill of health', only time to continue improving.

d. The committee's remit is to assess the Registrant's fitness to practise. The remit of the inspectors included assessing risk in allowing UK Meds to operate over a period when it was undergoing changes anticipated to address risk and would be subject to further inspections. Further inspection visits did occur leading, shortly after the Registrant left UK Meds, to Improvement Notices, Conditions and, ultimately, UK Meds choosing to discontinue its online prescribing service.

304. In addition, whereas GPhC inspectors could undertake occasional visits and receive information from UK Meds over a span of time, the Registrant was operating within the UK Meds prescribing model on a near-daily basis processing many patient Questionnaires and issuing many prescriptions. He was, therefore, well placed to assess how it worked and how that impacted on his professionalism. In this regard he had the advantage of his experience as a prescriber within a GP practice: there he saw patients face-to-face, had access to medical reports, could engage with the patients' GP, and could arrange for follow-up reviews. These were aspects of prescribing practise that he did not have when working within the UK Meds prescribing model. He was well placed to have understood how not being able to engage with patients in the way he did at the GP practice impacted on his ability to undertake safe prescribing practises and how it impacted on the safety of the UK Meds prescribing model overall. Nonetheless, he remained at UK Meds and issued many prescriptions for high-risk medication and/or drugs requiring ongoing monitoring. The committee acknowledges that after nearly five months he chose, to his own financial disadvantage, to leave UK Meds and did so, on his account, because of his patient safety concerns (though there is also evidence suggesting he left because he was not getting the level of work he expected, though this appears to have been because he was refusing prescriptions and referring patient orders to the Clinical Lead at a higher rate than UK Meds expected of him).

305. It is notable that in his statements and submissions to the committee, the Registrant made it clear that his current view is that he *"wholly disagrees"* with the online

model for prescribing because it supports unsafe prescribing. In his submissions at the end of Stage 1, the Registrant said:

> *"With hindsight, I will never do online prescribing again. Basically, at the time I didn't see anything wrong because if I had I would not have participated. My background made it a natural evolution for me to go into, part of the future."*

306. Earlier in the hearing, when making a statement, he commented:

> *"In my opinion today, we should not have prescribed dihydrocodeine using the UK Meds system. The GPhC should not have allowed that to happen. It should not have happened."*

and he went on to add

> *"Definitely no opioids and no Z-drugs should be prescribed online."*

And

> *"What I would say today, no modafinil, Z-drugs, opioids, or amitriptyline online today. But at the time at UK Meds, I had faith in the system, people bigger than me had assessed everything and decided everything was OK, so even though I had reservations, I was a new kid on the block."*

307. These comments contrasted with other comments he made during the hearing including *"The UK Meds Questionnaire is very comprehensive and very thorough"*. He stated that the patient Questionnaire approach was used in other bodies, and he referred to the NHS Out of Hours (OOH) hospital services, the NHS 111 and healthcare services regulated by the CQC. The committee has already considered these comments above.

308. At the end of the committee's findings in Particular 2 above, the committee concluded that it may be, as the Registrant has argued, that questionnaires can be used appropriately in healthcare settings. However, the committee further concluded that the appropriateness of questionnaires is likely to be dependent on the prevailing situation. As has been evidenced (and not disputed) the Registrant approved many prescriptions using the UK Meds prescribing model. As indicated above, the

committee finds that in the context of prescribing high-risk drugs and/or drugs requiring ongoing monitoring, his practice of approving prescriptions was not appropriate given that he failed in the ways set out in Particular 2 as enabled and encouraged by the UK Meds prescribing model.

309. The allegation in Particular 3 is that he prescribed high-risk drugs and/or drugs requiring ongoing monitoring in circumstances when the UK Meds prescribing model was incapable of supporting safe prescribing decisions.

310. The committee is satisfied that it prefers the opinions of Ms 1 regarding the UK Meds prescribing model in the context of prescribing high-risk drugs and/or drugs requiring ongoing monitoring. The UK Meds prescribing model as it operated, had as its default position an acceptance of prescribing such drugs, even repeatedly over many months to the same patient, on the basis that:

a. the patient was not seen or spoken to,

b. patients could pre-select medicines even though current guidance was that patients should not be able to do so,

c. patients could change their answers to questions in response to advice from the UK Meds system and thereby manipulate the patient Questionnaire without this being apparent to prescribers,

d. prescribers could prescribe without reliable information to corroborate the information provided by the patient such as with access to GP records,

e. prescribers could prescribe without significantly inquiring into patient refusals to give consent,

f. prescribers did not access GP records even when consent was given, and

g. there were inadequate arrangements for ensuring GPs were informed when drugs were prescribed or for ensuring that arrangements for monitoring and reviews were in place as expected by guidance.

311. The circumstances relating to Patient 10, referred to above and below, is an example of how the UK Meds prescribing model did not support safe prescribing decisions.

312. Given the committee's review and analysis of the evidence and issues above, the committee is satisfied that the UK Meds prescribing model was incapable of supporting safe prescribing decisions relating to high-risk drugs and/or drugs requiring ongoing monitoring. The Registrant worked within that model and while doing so issued prescriptions for high-risk drugs and/or drugs requiring ongoing monitoring.

313. **In the light of all the above, the committee finds Particular 3 proved in its entirety.**

Particular 4

4. In relation to 1 above, you prescribed a significant portion of prescriptions in circumstances where the time taken would not have been sufficient for you to clinically evaluate the suitability of the medicines to the patient including:

4.1. read, consider and assimilate the completed questionnaire;

4.2. consider if it was clinically necessary to check with the patients' GP and/or contact the GP;

4.3. consider if it was clinically necessary to contact the patient and/or conduct a face-to-face consultation with the patient;

4.4. consider if it was necessary to check the clinical background of the patient and/or check the clinical background;

4.5. consider the steps you ought to take to prescribe in accordance with UK prescribing guidance as set out at 2 above.

314. The analysis of Particular 4 starts with the disclosures made by UK Meds through their lawyers to the GPhC referred to above under the analysis of Particular 1. This included the disclosure of spreadsheets of data relating to prescriptions issued by the UK Meds prescribers including the Registrant. As summarised above, the spreadsheets were merged and filtered by Mr 1, Senior Data Analyst and Insight Manager at the GPhC, to focus on 'High-Risk Controlled Drugs' (Schedules 3, 4 and 5, such as dihydrocodeine) and 'High-Risk but Not Controlled Drugs' (such as amitriptyline).

315. The spreadsheets include columns described as *"created at"* and *"review date"*. These terms are explained in witness statements dated 13/9/2021 and 20/9/2022 provided by a person referred to as "Director 1". Director 1 was a Director of UK Meds who provided the statements and attached schedules in response to the GPhC's requirement for disclosure of information from UK Meds. Director 1 states that his statement is prepared in their capacity as a Director of UK Meds and that the Board of Directors of the Company had seen the witness statement and approved the provision of it, and the schedules attached to it, to the GPhC. The second statement was provided through lawyers acting for UK Meds. In these circumstances, the committee is satisfied that it can rely on the information provided.

316. Within the statements and schedules provided by Director 1 are the following definitions:

> *"created at"* means *"the exact time the consultation* [i.e. Questionnaire] *was submitted by the patient, I.e, the exact time the consultation was created in the UK Meds system."*, and
>
> *"review date"* means *"the exact time/date the consultation was reviewed by the prescriber."* Which Director 1 went on to clarify as *"It is the exact time at which the prescriber clicks the approve/refuse button."*

317. The written and oral evidence of Ms 4, the Lead Case Officer for the GPhC responsible for investigating the matter, describes how she used the "Combined List – with Customer Name Removed" (Exhibit SE1) spreadsheet produced by Mr 1 to analyse the time taken by the Registrant to review patient orders for medication and to issue a prescription. For the reasons given above, the committee is satisfied that she was appropriately able to analyse the spreadsheets.

318. Ms 4 describes how she filtered the spreadsheet to review the time taken:

a. Between the "created at" time and the "review date" for individual prescriptions issued, and

b. Between "review date" and "review date" for consecutive prescriptions,

and did so breaking the time periods down into categories of between 'less than or equal to 1 minute', between '1 to 3 minutes', between '3 to 5 minutes' and 'greater than 5 minutes (which could mean 5 minutes and 1 second or many minutes or even hours).

319. The committee accepts that Ms 4 had the skills and ability to undertake what is relatively straight-forward analysis of an Excel spreadsheet.

320. Having done so, Ms 4 produced the following two charts:

"created at" to "review time" (time between creation of the order and its approval)

Relevant Period	Prescriber	<=1 min	<=3 mins	<=5 mins	>5 mins
20 May 2019 to 15 October 2019	Mobolaji Onafuwa	110	477	274	10,903

"review time" to "review time" (time between consecutive order approvals)

Relevant Period	Prescriber	<=1 min	<=3 mins	<=5 mins	>5 mins
20 May 2019 to 15 October 2019	Mobolaji Onafuwa	5,121	4,225	863	1,554

321. The committee has, with this evidence, considered the terms of Particular 4.

322. It may be that some specific individual steps set in Particulars 4.1 to 4.5 may have been achievable in relatively short periods of time. However, the gravamen of Particular 4 is in the stem of Particular 4, the opening lines which refer to *"the time taken* [to decide to prescribe] *would not have been sufficient"* to complete all the steps required to make a safe prescribing decision, *"including"*, collectively, those

listed at 4.1 to 4.5. Accordingly, the committee has not had to consider the sub-Particulars 4.1 to 4.5 individually, but has considered Particular 4 as a whole.

323. The Registrant has submitted that there is no expert evidence as to the standard of time taken to issue prescriptions nor does it have any comparison data with other prescribers working at UK Meds. He has further submitted that the time he took to issue prescriptions was longer than the time allocated in other healthcare settings, albeit the committee has no evidential material in support of this assertion. Based on these submissions, the Registrant has argued that the committee cannot find Particular 4 proved.

324. The Registrant went on to state that he was able to *"read, assimilate, make an assessment and decide"* on a patient Questionnaire *"within 1 minute 11 seconds".*

325. Regarding his approach to prescribing, he has said that he was looking for reasons not to prescribe and in the event of not identifying any, he would prescribe and it was this approach that enabled him to review patient Questionnaires quickly. He described his ability to 'speed read' patient Questionnaires and how he was looking for *"key phrases, not the waffle about it"* that would trigger further consideration of a patient's Questionnaire. The committee concludes that this is an approach more akin to the role of a dispensing pharmacist who must check the appropriateness of a prescription and of dispensing against it. His approach is not in line with the role of a prescriber who has to determine a justification for issuing a prescription rather than a justification for not issuing a prescription. His approach was in line with his understanding of being 'patient centred' which, in his statements to the committee, equated with giving medicines to patients who asked for them unless there was a good reason not to do so. It is clear from the copy patient Questionnaires that the committee has seen, that whilst some of the questions required a 'Yes' or 'No' answer, others had space for the patient to add text and there are examples of lengthy text being added by patients. This text would need to be read and considered carefully and the task for doing so would be the greater if the patient had a history with UK Meds and there were earlier completed patient Questionnaires that would need to be read and contrasted. The committee was concerned that he could dismiss what he referred to as *"waffle"* in the answers given by patients, "waffle" that could,

unless read with care, contain important information or prompt clinical consideration.

326. Regarding his approach to assessing risk, he was clear in his statements to the committee that he had and applied his own risk framework and did not use or adopt the framework for identifying high-risk medicines presented by the GPhC. He gave his "definition" of risk as follows:

i. Those medicines liable to cause death or disability when misused or abused within a short space of time, *"say 3 months"*, which he equated with *"High risk"*,

ii. Those medicines liable to cause death or disability when misused or abused over a period of more than three months, which he equated with *"Medium to High risk"*,

iii. Those medicines not liable to cause death or disability but which nonetheless can be misused or abused, which he stated *"covers most drugs"* and he equated with *"Low to Medium risk"*, and

iv. Those medicines not liable to cause death or disability but may be subject to abuse, which he compared with *"giving some pleasing effect"* and which he equated with *"Low to medium risk"*.

327. He acknowledged that *"This is not a scientific or proven classification. But I, as an experienced clinician, disagree with the GPhC classification where there is* [in the GPhC] *a dearth of clinical experience"*. He argued that the GPhC definition *"has no basis in law and no basis on science"*. He accepted that *"Some GPs may disagree with my definition".*

328. The GPhC understanding of "High Risk" for the purposes of the case is based on the GPhC April 2019 guidance in effect at the relevant time. The GPhC April 2019 guidance provides general guidance regarding prescribing online, but goes on to state that:

"some categories of medicines are not suitable to be supplied online unless further safeguards…have been put in place to make sure that they are clinically appropriate."

And which then goes on to describe those categories to include:

"Medicines liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important."

And

"Medicines that require ongoing monitoring or management."

329. It is not for the committee to make its own assessment of relative risk of medicines. What the committee can do however is note that the Registrant's view is significantly out of line with that of the profession and regulators. He illustrated his approach to assessing risk by arguing that paracetamol is a higher risk than dihydrocodeine and that water is high-risk given that it can kill if consumed to excess. By law dihydrocodeine is a Controlled Drug whereas paracetamol is not and is available without prescription. When considering the answers given in a patient Questionnaire, the Registrant would also have to have in mind guidance such as NICE guidance for Controlled Drugs, and the guidance contained in the BNF, guidance that is based on the profession's risk framework, not the Registrant's.

330. In addition, whether he accepts the GPhC's analysis or not, he was under a professional obligation to apply the GPhC April 2019 guidance when working at UK Meds.

331. However, what is clear now is that he was, on his own admission, unaware of the GPhC's April 2019 guidance for much of the time that he worked at UK Meds. For reasons given above (under Particular 2) the committee concluded that he should have known about the GPhC's April 2019 guidance and should have been applying it.

332. A consequence of his approach to assessing risk was that he did not accept that the medicines listed by the GPhC as high-risk were in fact high-risk but instead was applying his own framework. The committee finds that this approach by him is in part an explanation for why he was able to prescribe as quickly as he did, given that in his mind, *"I did not prescribe any high-risk drugs".*

333. The committee is satisfied that it can properly apply its skills to assess whether it is reasonable to consider properly and safely patient Questionnaires for medication in less than five minutes. It is satisfied that this is not reasonable, particularly in those cases involving high-risk medications and patients who had previously ordered medication from UK Meds when there would not only be the current patient Questionnaire to review but also previous Questionnaires which would need to be compared and contrasted with the current Questionnaire, along with any notes made by previous UK Meds prescribers. The committee was also concerned that his risk framework did not appear to cover medicines that may require ongoing monitoring which are an element of Particular 1 and which would require additional time for him to have considered when making a prescribing decision.

334. The fact that he was, in many instances issuing prescriptions in relatively short periods of time, is consistent with what he has said to the committee about his approach to prescribing and his approach to assessing risk.

335. As it is, the committee concludes that his approach to prescribing unless there was a reason not to, and his approach to assessing risk that concluded, for example, that dihydrocodeine is not high-risk, facilitated his ability to prescribe in very short amounts of time.

336. When reviewing Particular 4, the committee has also had in mind the Registrant's statements to the committee that his approach was to review several patients at the same time, by lining up patient Questionnaires seeking the same medication alongside each other, filtering out those where he identified concerns and approving the remaining orders. This approach may go part way to explaining why there is a high number of *"review date"* to *"review date"* prescriptions issued in quick

succession. It is an approach that is consistent with the Registrant's statement of prescribing unless he identified a reason not to prescribe. However, it is an approach that does not support a patient centred approach which requires sufficient consideration to be given to individual patients, particularly those who had made previous orders and their previous patient Questionnaire would need to be considered before a prescription could be issued.

337. The committee accepts that in some instances, he may have considered patient Questionnaires with some care. He has referred to the instance when he identified a patient who was under 10 years of age and who should have been filtered out by the system before being put to a prescriber. Whilst it is positive the Registrant spotted this instance, it does not establish that he was always taking sufficient time to clinically evaluate all orders for medication.

338. The committee also accepts that there is evidence that in some cases he took substantially longer than 5 minutes to clinically assess patient Questionnaires, but again, these instances do not establish that he was always taking sufficient time to clinically evaluate all orders for medication.

339. Finally, the committee is satisfied that when assessing Particular 4 and the reference to *"a significant proportion"*, the committee is not constrained to simply take a numerical approach but should consider the number and nature of the drugs being prescribed in under five minutes. The evidence shows that in many instances, the numbers of prescriptions issued included high-risk medicines and/or ongoing monitoring, and also to patients who had made previous orders for such medication.

340. Given the above analysis, the committee concludes that he did prescribe a significant proportion of prescriptions for high-risk drugs in circumstances when the time taken would not have been sufficient for him to clinically evaluate the suitability of medicines prescribed.

341. **Accordingly, the committee finds Particular 4 in its entirety proved.**

Particular 5

5. In relation to 1 above, on or around 23 May 2019, you prescribed 100 tablets of Dihydrocodeine 30mg to Patient 10, in circumstances where you:

5.1. knew or should have known that

5.1.1. the patient had already made repeated orders on 18 previous occasions for the same medicine from UK Meds Direct Ltd;

5.1.2. the patient put the same or very similar answers into each questionnaire.

5.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;

5.3. relied principally on questionnaire answers whereby it was unverified information;

5.4. failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

5.5. failed to request a face-to-face consultation with patients in order to examine the clinical need for medication;

5.6. failed to adequately consider the possibility of medication dependence and misuse;

5.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or

5.8. failed to put adequate safety-netting in place.

342. In reviewing Particular 5, the committee has had regard to its analysis of Particular 2 above, including the references given to the relevant RPS 2016 and GPhC April 2019 guidance documents. To those references, the committee highlights the following reference in the RPS 2016 guidance:

"2.7 Identifies, accesses, and uses reliable and validated sources of information and critically evaluates other information."

343. Particular 5 as a whole is set in the context of Particular 1, namely instances when the Registrant has issued medicines that are high-risk and/or requiring ongoing monitoring. These drugs include dihydrocodeine.

344. The Registrant did not contest that on or around 23/5/2019 he prescribed 100 tablets of dihydrocodeine 30mg to Patient 10.

345. The documentary evidence showing that the Registrant issued a prescription to Patient 10 appears as follows:

a. The committee has seen a copy of a prescription for dihydrocodeine dated 23/5/2019 issued in the name of the Registrant to Patient 10.

b. The evidence of Ms 4 provides a schedule of sixteen occasions when Patient 10 was prescribed dihydrocodeine between 12/4/2017 and 23/5/2019.

c. Ms 4's table shows that on each of the sixteen occasions over 2017 and 2019 shown in her schedule UK Meds prescribers prescribed her 100 tablets of dihydrocodeine 30mg. i.e. The same prescription on each occasion.

d. A schedule provided by UK Meds through their lawyers to the GPhC of Questionnaires submitted by Patient 10 to UK Meds. The schedule shows that Patient 10 submitted ten completed Questionnaires to UK Meds between 24/4/2018 and 23/5/2019: four occasions over approximately six months in 2018; and six occasions over approximately five months in 2019.

e. The documentation includes copies for fourteen Questionnaires submitted by Patient 10 including the one submitted by Patient 10 which the Registrant reviewed and then issued a prescription.

f. Whilst Ms 4's table only showed those instances when a prescription had been issued, there was evidence that Patient 10 had submitted Questionnaires to UK

Meds ordering medication on other occasions going back to 2016 when no prescription had been issued.

g. The documentation includes six of the earlier prescriptions issued to Patient 10 (between 25/4/2018 and 28/1/2019). On each occasion, the prescription issued includes a note reading in part *"Short-term use only. This medication can cause addiction."* a text that is then repeated on the label to the medication prescribed by the Registrant.

h. There is no evidence to show that on any occasion any UK Meds prescriber either spoke with Patient 10 or had access to her medical records.

i. The Registrant has not disputed issuing a prescription to Patient 10. His case has been to emphasise that the dihydrocodeine he prescribed to Patient 10 was not delivered. The fact it was not delivered was not his responsibility.

346. **The committee was satisfied that the stem of Particular 5 was proved.**

347. The committee notes here that the Registrant emphasised throughout the hearing that the dihydrocodeine he prescribed did not reach Patient 10. This was not contested by the GPhC in the hearing. Part of the Registrant's anxiety throughout Stage 1 of the hearing was, as he reported, that the GPhC had, at Interim Order hearings submitted that medication he prescribed Patient 10 caused Patient 10 harm.

348. **Particular 5.1 alleges that the Registrant knew or should have known that:**

5.1.1. the patient had already made repeated orders on 18 previous occasions for the same medicine from UK Meds Direct Ltd; and

5.1.2. the patient put the same or very similar answers into each questionnaire.

349. Whilst Ms 4's schedule lists sixteen occasions when Patient 10 ordered dihydrocodeine from UK Meds dating between 2017 and 2019, UK Meds disclosures include a schedule of twenty-four occasions when Patient 10 ordered the drug from UK Meds going back into 2016, albeit the 2016 orders were mostly cancelled. The

committee is satisfied that Patient 10 ordered the drug *"on 18 previous occasions"* prior to the Registrant considering a Patient 10 order, albeit it could have been more occasions than 18.

350. The UK Meds disclosures advise that UK Meds prescribers had access to the UK Meds system which included the UK Meds medical records for patients. The UK Meds patient records included previous patient Questionnaires and prescriptions issued. The Registrant has accepted that he had access to some past UK Meds records but, in his statements to the committee variously suggested he had access to the 2018 and 2019 records but not to records from 2017 and also at a different stage of the hearing suggested that he did not have access to records from more than six months before he considered Patient 10 (which would have included the previous 7 prescriptions).

351. The Registrant also referred to the fact that the day he prescribed dihydrocodeine to Patient 10 on 23/5/2019 which was just days after he had started work at UK Meds on 20/5/2019 and when he was learning to use the UK Meds system.

352. The allegation in Particular 5.1 is that he should have known that Patient 10 had made previous orders for dihydrocodeine. Having reviewed the evidence, the committee accepts that he should have done so and rejects his submission that he did not. The committee is satisfied that the UK Meds system kept patient records showing orders submitted and prescriptions made and that he should have been able to access those records at the time.

353. **Accordingly, the committee is satisfied that Allegation 5.1.1 is proved.**

354. The committee has copies of a number of Questionnaires submitted by Patient 10 during 2018 and into 2019 up to and including the Questionnaire reviewed by the Registrant. They show a consistent theme in the answers provided relating to the pain the patient reported suffering, its causes in particular tension headaches and pain caused by endometriosis, and her engagement with health care professionals for treatment, including reporting that her GP had prescribed dihydrocodeine but difficulties in obtaining prescriptions/treatment from her GP.

355. **Accordingly, the committee is satisfied that Allegation 5.1.2 is proved.**

Particular 5.2 alleges that the Registrant failed to obtain adequate information in relation to Patient 10's health in advance of prescribing.

356. The committee considered 5.2 below after Particular 5.6.

Particular 5.3 alleges that the Registrant relied principally on questionnaire answers whereby it was unverified information.

357. In reviewing Particular 5.3, the committee has also had regard to its analysis of Particular 2 above, in particular Particular 2.1 (inadequate information) and 2.5 (reliance on Questionnaire), including the references given to the relevant RPS 2016 and GPhC April 2019 guidance documents.

358. In addition to the patient Questionnaire the Registrant reviewed on 23/5/2019, the Registrant also had access to previous Questionnaires submitted by Patient 10 and the prescriptions issued by previous UK Meds prescribers. He did not have access to GP records or the records of other healthcare professionals who, as disclosed by Patient 10, were treating her. He was, therefore primarily relying on the patient Questionnaire that Patient 10 submitted, which contained patient reported information.

359. The answers given by Patient 10 were unverified by any other source such as her GP or other healthcare professionals.

360. What is now clear, by comparing Patient 10's answers and the GP records, is that the answers given by Patient 10 were not comprehensive, including the fact that she did not disclose her dependence on opioids.

361. There are aspects of the answers given in the patient Questionnaire that should have prompted further inquiry. For example, the Patient's completed Questionnaire reviewed by the Registrant on 23/5/2019 shows the patient's weight as 11 stone. The previous Questionnaire, reviewed by a UK Meds prescriber on 24/4/2019 shows the patient's weight as 11.05 stones. The Questionnaire before that, reviewed by a UK

Meds prescriber on 5/4/2019, shows the patient's weight as 13 stones, indicating a significant loss of weight over a matter of weeks by the time the Registrant considered Patient 10. Significant loss of weight ought to have prompted further inquiries before prescribing and/or arrangements for monitoring and review.

362. The requirement of the RPS 2016 and GPhC April 2019 guidance for prescribers to have adequate information requires prescribers to consider the reliability of the information that is available: adequate information would, of necessity, have to be adequate reliable information.

363. The committee finds that the answers given by patients on Questionnaires cannot be regarded as wholly reliable for the purposes of prescribing high-risk drugs and drugs requiring ongoing monitoring. Even with the best will, patients cannot be relied upon to be comprehensive or accurate narrators of their medical history. Patients are not generally clinicians. Patients, even when trying their best, may forget or mis-recall or misunderstand medical details regarding their medical history including blood tests, diagnosis and treatments. It is also possible that patients may not be comprehensive, leaving out circumstances that they do not believe to be relevant when in fact they may be relevant to a clinician. Moreover, patients may be misusing, abusing or addicted to drugs and may therefore actively give answers that are incorrect or incomplete or misleading answers. The purpose of a two-way dialogue referred to by Ms 1 is to mitigate the risk that information from patients may be incomplete and/or inaccurate.

364. This general view of patient reliability applies to Patient 10. Without a reliable secondary source of information, Patient 10's answers would need to be regarded as unverified and their reliability in issue, particularly in the context of prescribing a high-risk drug that is addictive and can be misused.

365. Given that the Registrant primarily relied on the answers in Patient 10's Questionnaire, and did not have access to other sources of information, for example a two-way dialogue with Patient 10 and/or access to Patient 10's medical records outside of UK Meds, he was relying on the unverified patient answers on the Questionnaires, and this was not in line with the relevant guidance.

366. **Accordingly, the committee finds Particular 5.3 proved.**

Particular 5.4 alleges that the Registrant failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history.

367. In reviewing Particular 5.4, the committee has also had regard to its analysis of Particular 2 above, in particular Particular 2.1 (inadequate information) and 2.3 (access to GP records), including the references given to the relevant RPS 2016 and GPhC April 2019 guidance documents.

368. As recorded above, Patient 10 referenced in her answers engaging with her GP and with other healthcare professionals. She also refused consent for UK Meds to contact her GP and no contact was made by UK Meds to her GP.

369. The committee finds that he did not access, and did not seek to access, Patient 10's GP records, a fact not contested by the Registrant.

370. As reviewed above, the committee finds that he should have sought to access her GP and medical records to verify what she self-reported but did not do so and instead simply issued a prescription for dihydrocodeine based on her self-reported patient Questionnaire alone.

371. **Accordingly, the committee finds Particular 5.4 proved.**

Particular 5.5 alleges the Registrant failed to request a face-to-face consultation with patients in order to examine the clinical need for medication.

372. In reviewing Particular 5.5, the committee has also had regard to its analysis of Particular 2 above, in particular Particular 2.1 (inadequate information) and 2.4 (face-to-face consultations), including the references given to the relevant RPS 2016 and GPhC April 2019 guidance documents.

373. The Registrant's case is that he could not request a face-to-face consultation for himself. His statement is that he could refer a patient request to the Clinical Lead who could consider seeking a face-to-face consultation with the patient. There is no

evidence that the Registrant referred Patient 10 to the Clinical Lead and given that he in fact issued a prescription, the committee can be satisfied that he did not do so.

374. The Registrant's case is that a face-to-face consultation with Patient 10 would have added nothing to what was known from her answers to the patient Questionnaire. He accepted in his statements to the committee that addicts may lie about their condition. His case was that addicts can hide their addiction and present in a manner that is consistent with their reported condition. His case was that the quality of the UK Meds patient Questionnaire was good enough to mean that a face-to-face consultation would not add to the information available to a prescriber.

375. The committee is satisfied that he should have sought a face-to-face consultation and if that was to be achieved by referring the matter to the Clinical Lead that is what he should have done. The committee reaches this conclusion given that Patient 10 had by that stage been receiving prescriptions for dihydrocodeine from UK Meds for many months and that should have been known to the Registrant from the UK Meds patient records to which he had access. The committee accepts that some patients who have a dependency on opioids may well be able to hide their dependence. However, it is also the case that patients may also present with signs of their dependency and/or may provide information additional to that given in the patient Questionnaire. The information available to the Registrant, in particular that Patient 10 had been apparently using dihydrocodeine for many months or even years, was enough to require further inquiries, including by way of a face-to-face consultation when additional information may have been available relevant to making a safe clinical prescribing decision.

376. **Accordingly, the committee finds Particular 5.5 proved.**

Particular 5.6 alleges that the Registrant failed to adequately consider the possibility of medication dependence and misuse.

377. In reviewing Particular 5.6, the committee has also had regard to its analysis of Particular 2 above, in particular Particular 2.1 (inadequate information) and 2.5 (access to GP records), including the references given to the relevant RPS 2016 and GPhC April 2019 guidance documents.

378. Recognising the risk of dependency is reflected in the RPS 2016 guidance by reference to monitoring for adverse effects, explicitly in NICE guideline on 'Controlled drugs: safe use and management', and explicitly in the GPhC April 2019 guidance at page 18.

379. The Registrant's case focused on Patient 10 being a nurse who would know about the addictive nature of dihydrocodeine. The fact that she was a healthcare professional appears, from his own account, to have given him reassurance about the correctness of issuing, as he did, the prescription for dihydrocodeine. In the committee's assessment, he has overlooked the reality that even healthcare professionals can become addicted to opioids and may, by their qualifications, be in a better position than others to provide a credible medical history that masks their addiction.

380. His approach in not considering the risk of opioid dependency and in issuing a prescription without adequate information appears to the committee to be underpinned by his view of dihydrocodeine. In his statements to the committee, the Registrant expressed the view that *"I did not prescribe any high risk drugs"*. In statements to the committee the Registrant expressed the view that in his opinion paracetamol is a higher risk medication than dihydrocodeine given that an overdose of paracetamol can cause death relatively readily whereas that is not a risk with dihydrocodeine. He placed less significance on the addictive nature of dihydrocodeine (and the significant harm that may follow addiction/dependency). It is not for the committee to make its own assessment of relative risk of medicines. What the committee can do however is note that the Registrant's view of what constitutes high-risk drugs is significantly out of line with that of the profession and regulators as a whole which classify dihydrocodeine as a Controlled Drug whereas paracetamol is not and is available without prescription.

381. **Accordingly, the committee finds Particular 5.6 proved.**

Particular 5.2 alleges that the Registrant failed to obtain adequate information in relation to Patient 10's health in advance of prescribing.

382. The committee here returns to consider Particular 5.2.

383. The need to obtain adequate information is referred to in the guidance documents.

384. The RPS 2016 guidance has a section on:

> *"1. Assess the Patient"* and describes the need to take an appropriate medical, social and medication history, undertaking a clinical assessment and assessing *"available and relevant"* patient records.

385. The GPhC April 2019 guidance refers to staff, such as the Registrant, having *"all the information they need"* to ensure *"safe and appropriate"* supply of drugs to patients.

386. The committee was therefore satisfied that he was under a professional obligation to obtain adequate information before prescribing and that this obligation was particularly significant when prescribing high-risk drugs or drugs requiring ongoing monitoring such as dihydrocodeine.

387. He has issued the prescription to Patient 10 essentially on the basis of information from one source, namely the self-reported patient Questionnaire.

388. Having regard to Particulars 5.3, 5.4, 5.5 and 5.6 above, the committee has already found that the Registrant issued Patient 10 a prescription:

a. Relying principally on questionnaire answers provided by Patient 10 that were unverified by any other source,

b. Failed to access Patient 10's GP records for medical information and verification of Patient 10's answers,

c. Failed to request face-to-face consultations with Patient 10 to adequately examine the need for medication, and

d. Failed to consider the possibility of medication dependence and misuse by Patient 10.

389. Given these findings, the committee finds, with regard to Particular 5.2, that he failed to obtain adequate information in advance of prescribing.

390. The committee has further considered the evidence in relation to Particular 5.2 as follows.

391. The format of the earlier patient Questionnaires did not seek consent for UK Meds to contact Patient 10's GP. The format of later patient Questionnaires did seek consent from patients for UK Meds to contact their GP. On these patient Questionnaires (relating to prescriptions issued on 24/4/2019 and 23/5/2019) Patient 10 had answered *"No"*, refusing consent for UK Meds to contact Patient 10's GP. The completed Questionnaire reviewed by the Registrant was one of those in which Patient 10 answered *"No"* refusing that consent.

392. The UK Meds records seen by the committee show no contact was had with Patient 10's GP.

393. The Registrant accepts that he prescribed dihydrocodeine without having contact with Patient 10's GP. There is no evidence that he inquired as to why consent was refused.

394. What Patient 10's GP records, confirmed by a pharmacist treating Patient 10, show that she was dependent on opioids, had a history of significant poor mental health, and other conditions for which she was being treated. The Registrant was unaware of this as he did not have contact with the GP nor access to the GP records.

395. Without access to the GP, and by relying on Patient 10's answers to the patient Questionnaire, the Registrant was unaware of Patient 10 being dependent on opioids, nor did he have an adequate clinical understanding of her full health conditions. Patient 10's answers in the patient Questionnaire appear not to have disclosed in full the medication she was receiving and appear not to have been comprehensive when compared with the GP records.

396. The committee is satisfied that if the Registrant had made appropriate inquiries before deciding whether or not to prescribe Patient 10 dihydrocodeine, he may well have learnt that she was dependent on opioids, that there was a significant mental health history, and of her health conditions and treatment she was receiving, any one of which would most likely have impacted on his decision to issue a prescription.

397. The committee is also satisfied that he should have sought to make such inquiries before issuing the prescription to Patient 10. The fact that she had, even on UK Meds

records, been receiving prescriptions for a significant amount of dihydrocodeine over many months and that she had refused consent for her GP to be contacted, ought to have prompted him to make such inquiries before issuing the prescription yet he did not do so. The committee accepts the evidence of Ms 1 that a refusal to give consent ought to prompt the question 'Why has consent been refused?'

398. His explanation is that Patient 10 reported being a healthcare professional working as a nurse, that in his view she would know the risks of addiction with opioid based medicines, that she provided a consistent narrative about her diagnosis and treatment for endometriosis, and that whatever the risks of opioid addiction/dependency they were outweighed by the public benefit in having a working nurse. He stated that had he seen an order from Patient 10 for dihydrocodeine the following month, he would have considered it further because she should, by then, have recovered from her self-report of having an operation to treat her endometriosis. He went on to argue that if she was addicted she would have removed herself from practice in accordance with her professional standards.

399. The committee rejects his explanation. The committee finds he has proceeded on the basis of a number of wrong assumptions including assuming that a healthcare professional could not be addicted to/dependent on opioids, assuming that the information she provided was accurate and comprehensive, and assuming she would have removed herself from practise if addicted/dependent. Further that he made these assumptions when Patient 10 was seeking high-risk addictive drugs and therefore in circumstances when unverified answers ought to be scrutinised with a degree of professional scepticism and independent verification sought.

400. What he did know, or should have known, from the UK Meds records was that she had been receiving prescriptions for a significant amount of dihydrocodeine for many months or even years, on prescriptions that read the drug was for *"Short-term use only",* for a drug that can lead to dependency, and that whatever her role in society it could not be a justification for overlooking the significant risk of harm that can come from dependency and addiction to opioids.

401. **Given the above analysis, the committee finds Particular 5.2 proved.**

Particular 5.7 alleges that the Registrant failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring.

402. As with other sub-particulars to Particulars 5, this particular reflects the relevant guidance in place at the time the Registrant prescribed dihydrocodeine to Patient 10.

403. The RPS 2016 guidance has a specific section on *"Monitor and Review"* (Section 6) which reads as follows:

> *"6: MONITOR AND REVIEW*
>
> *6.1 Establishes and maintains a plan for reviewing the patient's treatment.*
>
> *6.2 Ensures that the effectiveness of treatment and potential unwanted effects are monitored.*
>
> *6.3 Detects and reports suspected adverse drug reactions using appropriate reporting systems.*
>
> *6.4 Adapts the management plan in response to on-going monitoring and review of the patient's condition and preferences."*

which makes clear a professional expectation for arrangements to be in place for the review and monitoring of the effectiveness of treatment.

404. The GPhC April 2016 guidance includes the following under the heading concerned with *"further safeguards"* required to be in place when prescribing medicines liable to abuse and medicines requiring ongoing monitoring or management:

> *"you have assured yourself that the prescriber will proactively share all relevant information about the prescription with other health professionals involved in the care of the person (for example their GP)"*
>
> *"for medicines which are liable to abuse, overuse or misuse, or when there is a risk of addiction and ongoing monitoring is important, you have assured yourself that the prescriber has contacted the GP in advance of issuing a prescription, and that the GP has confirmed to the prescriber that the*

prescription is appropriate for the patient and that appropriate monitoring is in place"

and

"if there are circumstances where the person does not have a regular prescriber such as a GP, or if there is no consent to share information, and the prescriber has decided to still issue a prescription, you should assure yourself that the prescriber has made a clear record setting out their justification for prescribing"

405. Whilst the guidance is directed at pharmacy owners, it clearly sets out expectations on individual prescribers such as the Registrant and, as the committee has already found, he should have been aware of it.

406. There is no dispute that the Registrant did not make any arrangements for monitoring and review with Patient 10's GP – there was no contact by the Registrant with Patient 10's GP.

407. The Registrant denies Particular 5.7. His case was that he was satisfied that Patient 10 had a GP and was in regular contact with the GP and would therefore be subject to monitoring and review.

408. The committee rejects the Registrant's argument.

409. The Registrant knew, or should have known, that the prescription he issued Patient 10 was only the latest of many over several months. His responsibility for ensuring the appropriateness of a prescription remained whether it was for a repeat prescription (as in this instance) just as much as if it was a first prescription. The only account he had for the effectiveness of the medication was from Patient 10. Whilst Patient 10 referred to engaging with her GP and other healthcare professionals, the Registrant had no independent verification of her contact with a GP or other clinician, or her condition, or an overview of the treatment she was receiving or the effectives of the treatment in particular the impact of the dihydrocodeine that was being prescribed by UK Meds. The UK Meds prescriptions advised that the dihydrocodeine was for *"Short term use only"* and *"This medication can cause*

addiction" yet it was still being prescribed after many months and without UK Meds having any clinical feedback on the impact of the medication prescribed. He could not be assured that a GP was engaged, or that any engaged GP and treating clinicians knew about the dihydrocodeine dispensed by UK Meds to Patient 10, or were in a position to take it into account when treating Patient 10. The Registrant appears to have treated Patient 10's request as a repeat prescription which he has approved without undertaking the clinical review expected of him as a prescriber.

410. In many respects, as with other prescriptions, the Registrant appears to have acted more as a dispensing pharmacist responsible for checking a prescription before dispensing than as a prescriber with responsibilities to justify issuing a prescription in the first place.

411. **Accordingly, the committee finds Particular 5.7 proved.**

Particular 5.8 alleges the Registrant failed to put adequate safety-netting in place.

412. Ms 1's evidence included a definition of *"safety-netting"* in a glossary of terms as follows:

> *"Safety netting was defined as a consultation technique to communicate uncertainty, provide patient information on red-flag symptoms, and plan for future appointments to ensure timely re-assessment of a patient's condition."*

413. The Registrant referred to a definition of safety-netting from the BMJ which he summarised as 'a consultation technique used to manage clinical uncertainty'.

414. The RPS 2016 provides the following guidance:

> *"5.1 Checks the patient/carer's understanding of and commitment to the patient's management, monitoring and follow-up.*
>
> *5.2 Gives the patient/carer clear, understandable and accessible information about their medicines (e.g. what it is for, how to use it, possible unwanted effects and how to report them, expected duration of treatment).*

5.4 Ensures that the patient/carer knows what to do if there are any concerns about the management of their condition, if the condition deteriorates or if there is no improvement in a specific time frame."

415. The RPS 2016 guidance is directed at prescribers such as the Registrant.

416. The GPhC April 2019 guidance provides the following under Principle 4 (which is concerned with safeguarding patient health, safety and wellbeing):

"make sure people receiving pharmacy services know who to contact if they have any questions or want to discuss something with the pharmacy staff"

417. And, under Principle 4.4

"Information for pharmacy users"

"You must give clear information to people who use your pharmacy services about how they can contact your pharmacy staff if they have any problems or need more advice. This should also include advice on when they should go back to their GP or local pharmacist."

418. Whilst the guidance is directed at pharmacy owners it clearly sets out expectations on individual prescribers such as the Registrant and, as the committee has already found, he should have been aware of it albeit he has accepted that he was not aware of the GPhC Guidance for much of the time he was working with UK Meds.

419. The GPhC's case was that by not having contact with patients, he failed to provide appropriate safety-netting.

420. The Registrant's case was that he could take the view that Patient 10 *"was not opioid naïve"* as she was a nurse, and had had dihydrocodeine before. He was satisfied that Patient 10 had the relevant leaflet which provided adequate safety-netting along with the prescription label on which he typed, repeating advice on earlier labels, that the dihydrocodeine was for *"Short-term use only"* and *"can cause addition".*

421. The committee takes the view that he could not be satisfied that adequate safety-netting was in place. Without a two-way dialogue with Patient 10 and/or contact with her GP /GP records, he could not be satisfied that she had an understanding of

and commitment to the management, monitoring and follow-up required. As with the analysis of Particular 5.7, the Registrant proceeded on the basis of a number of wrong assumptions, including that by assuming Patient 10 *"was not opioid naïve"* she could be relied upon to manage the risk of dependency/addiction, and assuming that she would be engaged with her GP to enable monitoring and review, and could not assume she would be open with her GP about obtaining drugs from an online source – in fact she did disclose this but the Registrant could not assume she would do so.

422. **Accordingly, the committee finds Particular 5.8 proved.**

423. Before concluding its analysis on Particular 5, the committee reviews further the Registrant's response to the particular. In his submission to the committee, the Registrant denied *"failing"* to do the things he was alleged to have failed to do in Particular 5. His case was that he *"considered each one in turn*" and assessed whether they would make any difference in this case and that he concluded they would not, that they were *"redundant"*. His assessment was that *"I was satisfied I had enough, I had enough to press on to prescribe and to do so as otherwise I would cause undue delay to Patient 10's care because my option then was to refuse* [to prescribe]".

424. The Registrant gave as an example *"a single mother with first child"* who telephones her GP to describe symptoms her child is experiencing from which the GP *"identifies possible sepsis"* and directs the mother to take her child straight to A&E. His comment was that there was *"no need"* for a face-to-face consultation and had the GP required to see child face-to-face it would have caused potentially harmful delay to the child getting to hospital for possible treatment. The committee concluded that the Registrant's example is flawed. In his example, the GP is not making a diagnosis and not prescribing treatment. Instead, the GP is undertaking a triage function, identifying a possible condition requiring urgent attention to receive a diagnosis and, if appropriate, receive treatment and directing the child to where diagnosis/treatment can be best delivered without delay. The GP's role in the example is not analogous to the Registrant's function when he, the Registrant, issued a prescription for high-risk drugs or drugs requiring ongoing monitoring. The Registrant, when prescribing was essentially relying on a diagnosis he was not

necessarily in a position to rely on and directing treatment through medication. The committee was concerned that the Registrant, in giving this flawed example, was demonstrating a lack of understanding of his role to ensure safety-netting was provided as a prescriber working online.

425. As set out above, the committee is satisfied that the acts set out in Particular 5 were not *"redundant"* but were steps he should have undertaken or considered further before making the prescribing decision and then following his decision to prescribe. When reviewing Patient 10's patient Questionnaire, he had three options: to 'Refuse' the order, to 'Refer' the order to a Clinical Lead to review, or to 'Approve' the order. As found above, he approved the order in circumstances when he failed to act in a number of ways that would have promoted the safety and wellbeing of Patient 10. The Registrant stressed that the prescription he issued to Patient 10 did not lead to any medication being supplied to her and that he could not therefore have contributed to her dependency. Nonetheless, the committee finds that as a fact he did issue the prescription to her, that his intention was that she should receive dihydrocodeine, and that she was a person with a significant dependency to opioid painkillers that was causing her harm and which resulted in her being admitted to a health centre on an emergency basis a matter of days after the Registrant issued the prescription. Accordingly, the Registrant's actions had the potential to cause Patient 10 harm by contributing to her dependency had she received the medication prescribed to her. The fact that she did not receive did not appear to be a result of any action by the Registrant.

426. The committee also records here that on a number of occasions the Registrant told the committee that he is now of the opinion that dihydrocodeine should not be prescribed through online prescribing services though that is exactly what he did in relation to Patient 10. In response to a question from the committee, the Registrant conceded that knowing what he knows now, he would not have prescribed dihydrocodeine to Patient 10.

427. **In summary, the committee finds the whole of Particular 5 including 5.1 to 5.8 inclusive proved.**

Particular 6

6. In relation to 1 above, you prescribed all or some of the medicines in Schedule A to patients in approximately the quantities outlined in that schedule on the basis of an online questionnaire when they are unsuitable to prescribed on that basis.

428. Schedule A lists nine drugs including opioids, Z-drugs and modafinil. All the drugs listed feature on the lists prepared Ms 3, Senior Clinical Advisor and Specialist Inspector at the GPhC. The lists were in three sections:

> 1) High-risk Controlled Drugs liable to abuse and/or misuse and/or overuse and/or toxic in nature, and habit forming,
>
> 2) High-risk Not Controlled Drugs liable to abuse and/or misuse and/or overuse and/or toxic in nature, and some may be habit forming, and
>
> 3) Other drugs to consider not habit forming but may require ongoing monitoring and management where risks may be relevant depending on person demographics, comorbidities and other drug interactions.

As such, they fall within the terms of Particular 1 which is concerned with high-risk medicines and medicines requiring ongoing monitoring.

429. The numbers of prescriptions, set out in Schedule A, for each drug issued by the Registrant whilst working at UK Meds comes from the spreadsheets provided by UK Meds and the analysis by witnesses from the GPhC. The committee has already concluded that it can rely on the spreadsheets provided by UK Meds and the analysis undertaken by GPhC witnesses, in particular Mr 1 and Ms 4.

430. Whilst he had denied Particular 6, the Registrant did not significantly dispute the evidence beyond questioning the ability of witnesses to undertake a correct analysis. The thrust of his submission was to assert that the numbers were not unduly high. He emphasised that UK Meds, providing a service country wide, could not be compared with the turnover of prescriptions in, for example, an average community pharmacy on a high street. He also emphasised that the numbers of prescriptions he issued was very small compared with the number of prescriptions issued nation-wide: he referred to a Google Search which suggested that the number of

Amitriptyline prescription issued in the UK in 2019 was in the region of seventy million. He went on to submit that the number of prescriptions he was alleged to have issued (in the region of eleven thousand) was small in comparison with the number of prescriptions issued by UK Meds as a whole which he put at 360,000 and over a six-month period.

431. Whilst the Registrant's statements summarised in the paragraph above may or may not be true, they are, the committee concluded, of little relevance to the committee's consideration of Particular 6 at this stage. The allegation in Particular 6 is simply that he issued prescriptions for specific drugs in the approximate numbers given in Schedule A.

432. For the committee's current purposes, therefore, the issue when reviewing Particular 6 is whether or not the committee is satisfied that the Registrant issued prescriptions for some or all of the medicines listed in Schedule A in approximately the numbers given in Schedule A. How those numbers compare with the number of prescriptions issued by UK Meds as a whole or in the UK annually, is not relevant.

433. Based on the spreadsheets and the analysis of the spreadsheets undertaken by Mr 1 and Ms 4, the committee is satisfied that the Registrant issued prescriptions for all the drugs listed in Schedule A in approximately the numbers given in Schedule A.

434. **Accordingly, the committee finds Particular 6 proved.**

Particular 7

7. On some or all of the occasions set out in Schedule B you prescribed the medicines to the patients outlined in that schedule in circumstances where you:

> ***7.1. knew or should have known that the patient had already made repeated orders for the same medicine from UK Meds Direct Ltd;***
>
> ***7.2. failed to obtain adequate information in relation to the patient's health in advance of prescribing;***
>
> ***7.3. relied principally on questionnaire answers whereby it was unverified information;***

7.4. failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history;

7.5. failed to request a face-to-face consultation with patients in order to examine the clinical need for medication;

7.6. failed to adequately consider the possibility of medication dependence and misuse;

7.7. failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring; and/or

7.8. failed to put adequate safety-netting in place.

435. Particular 7 is focused on patients to whom the Registrant issued a repeat prescription. That is to say, each patient had already received from UK Meds prescriptions for the same drug on a number of occasions over time and the Registrant was issuing yet another prescription for the same drug.

436. The RPS 2016 guidance does not distinguish between a prescriber issuing a first prescription and a prescriber issuing a second or subsequent repeat prescription: the requirements for safe prescribing remain the same. This is illustrated in Section 2 entitled *"Consider the Options"* where it reads *"2.2 Considers all pharmacological treatment options including optimising doses as well as stopping treatment".*

437. Similarly, the GPhC April 2019 guidance does not distinguish between a prescriber issuing a first prescription and a prescriber issuing a second or subsequent repeat prescription: the requirements for safe prescribing remain the same.

438. The requirement for safe prescribing even with repeat prescribing is illustrated by the GMC 2013 guidance, which reads:

"In providing clinical care you must:

a prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patient's

health, and are satisfied that the drugs or treatment serve the patient's needs."

And

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

439. Whilst the committee has found the GMC guidance to be of limited assistance in this matter, the Registrant accepted that the principles in it reflect the principles in later guidance. The committee is satisfied that this includes the principle that prescribers are responsible for ensuring that all prescriptions issued, whether repeat prescriptions or not, are clinically justified.

440. Ms 1's report does not distinguish between the responsibility placed on prescribers issuing initial and repeat prescriptions:

"In my opinion, a PIP is responsible for any prescription they write, should understand and work within local and national guidance when prescribing, recognises requests for high risk medications and work within all codes of conduct when interacting with the pharmaceutical industry."

441. In addition, Ms 1 highlights that:

"A prescriber, from a questionnaire based source, would surely have to question if the reason that the drug is being requested online because their own GP will not prescribe it due it being inappropriate or due to lack of clinical review, making repeat prescriptions clinically unsafe."

And

"If, for example, a patient was requesting medication online because they could not get a GP appointment, then, in my opinion, it remains unsafe for them to get continued repeat prescription as they are not being monitored by

their own GP or Practice Nurse. For example, a patient is requesting Pregabalin for Diabetic Neuropathy needs assessed regularly to ascertain any deterioration in foot care or overall diabetic control. It is simply not acceptable to continue to supply large quantities of a High Risk medication in the absence of GP review."

And

Before a PIP considers writing a "repeat", (patient states already prescribed), prescription for Modafinil, they need to assess the patient with regards to communication skills, take an appropriate history, (medical, psychosocial and medication including allergies), undertake and document an appropriate assessment, access relevant patient records, request relevant investigations, understand the nature of the of the condition being treated, reviews current medicines .

In the case of Modafinil, in my opinion, a PIP would need corroboration of a diagnosis of Narcolepsy, access to recent blood tests and evidence of a recent ECG, explore current dose and note any unwanted side effects and explore work, social habits and sleeping habits.

In my opinion, this information and assessment cannot be accessed from the self-populated online questionnaires and so Narcolepsy is not a condition, that a PIP can feel competent in prescribing for. I would also suggest, in my opinion, that a PIP is not therefore competent to diagnose Narcolepsy as this is done by specialists."

And

"Before a PIP writes a repeat prescription for a Gabapentinoid, in my opinion, they must consider all pharmacological and nonpharmacological treatments for neuropathic pain, (physiotherapy, TENS machine, Pain Clinic), consider increasing or decreasing current dose, consider not prescribing at all, assess comorbidities with regards to their impact on the patient's pain, consider

other routes of administration, be aware of high risk medication and local and national guidance on their prescribing and cost.

In my opinion, the self-populated questionnaire does not give adequate clinical information, does not corroborate any diagnosis of neurological pain, does not corroborate current dose, or if prescribed at all, has only self-reported information on addiction and mental health issues and should consider online requests for Gabapentinoids as a Red Flag due to its nature.

Therefore, in my opinion, a PIP cannot make evidence based decisions and therefore cannot comply with the expectations of the competency framework as a consequence of external factors i.e. the process/model they are operating within .In my opinion, without access to the medical records with relevant clinical history, recent examination and recent investigations, a PIP is likely to be unable to diagnose neuropathic pain and cannot make an evidence based decision on the information provided and should therefore not be prescribing a POM."

And, in the context of Z-drugs (Zopiclone and Zolpidem)

"In my opinion, a PIP cannot comply with the expectations of the competency framework and should not provide repeat prescriptions for night sedation in an online setting. They are also not safe, in my opinion, to diagnose a sleep issue from the self reported information provided."

And, in the context of repeat prescriptions for Co-codamol

"In my opinion, given the lack of a 2 way discussion, the lack of ability to assess literacy and understanding, the inability to locally signpost, and ensure safety netting advice is understood, a PIP is unable to safely prescribe Co-codamol in an online setting nor initiate it for newly diagnosed pain, as they cannot prescribe in accordance with the competencies set out in the prescribing framework."

442. The committee is satisfied that the Registrant issued the prescriptions listed in Schedule B. The committee reaches this conclusion based on the data provided by

UK Meds and the analysis of that data by the GPhC's witnesses culminating in the analysis by Ms 4.

443. The medications listed in Schedule B are all those listed within Schedule A being the high-risk medicines and the medicines requiring ongoing monitoring as selected for the purposes of this case.

444. Twenty-three patients are listed in Schedule B with a total of 42 prescriptions issued by the Registrant to these patients over the months that he worked for UK Meds (20 May 2019 to 15 October 2019).

Particular 7.1 alleges the Registrant knew or should have known that the patient had already made repeated orders for the same medicine from UK Meds Direct Ltd.

445. In relation to those items listed in Schedule B the evidence shows that these were to patients to whom there were multiple prescriptions issued by various prescribers working at UK Meds, the Registrant not being the first for any of them. The Registrant has given differing statements as to his access to earlier UK Meds Patient Medical Records including that he would not have had access to records from 2017, that he had access to records from 2018 and 2019, and that he might only have had access to records for the previous six months. All of the patients listed in Schedule B had received at least one prescription in the previous six months, and most had received multiple prescriptions in the previous six months. In some instances, he was responsible for a sequence of repeat prescriptions over a matter of months and with multiple prescriptions having been issued in the months immediately before. For example, by reference to patient identification number, Patients 156990 for Zopiclone, 20888 for co-codamol, 8976 for kapake/solpadol (co-codamol) and 63029 for codeine.

446. The committee is satisfied that he knew, or should have known, that the patients had already made repeat orders for medication.

447. **Accordingly, the committee finds Particular 7.1 proved.**

Particular 7.2 alleges the Registrant failed to obtain adequate information in relation to the patient's health in advance of prescribing.

448. The committee returns to consider this particular after Particular 7.6.

Particular 7.3 alleges the Registrant relied principally on questionnaire answers whereby it was unverified information.

449. The committee reviewed the relevant guidance and expectations placed on the Registrant in this regard in the context of Particular 2.2 and also in the context of Patient 10 at Particular 5.3.

450. The Registrant has not disputed that in terms of information sources he relied on the answers given by patients in the completed Questionnaires and that he would, as reviewed above, had some access to the UK Meds Patient Medical Records which would include previous patient Questionnaires.

451. For the reasons given above under Particular 5.3, the committee is satisfied that in the context of prescribing high-risk drugs and drugs requiring ongoing monitoring, the answers given by patients could not be regarded as wholly reliable in relating their medical history or medical condition, given the risk of patients forgetting or misunderstanding information, considering information not being relevant and therefore omitting to give it, and given the risk that patients may provide misinformation because of their misuse of drugs. In these circumstances, professional guidance requires prescribers to consider the accuracy and reliability of information and to seek verification when appropriate. In these circumstances, the committee would have expected a prescriber to seek verification of the information given either by engaging in a two-way dialogue with the patient and/or by reviewing the patient's GP clinical records. There is no evidence to show the Registrant did seek verification in this way. His options were to 'Refuse' the request for medication, 'Refer' the order to a Clinical Lead or to 'Approve' the order. The Registrant has approved the requests listed in Schedule B without verification.

452. Accordingly, the committee finds that he has relied principally on the unverified information in the patient Questionnaires.

453. **Accordingly, the committee finds Particular 7.3 proved.**

Particular 7.4 alleges the Registrant failed to access and/or attempt to access patient's GP medical records and/or specialist clinical records in order to have a full picture of their physical and/or mental health, current prescribed medication and/or addiction history.

454. In reviewing Particular 7.4, the committee has had regard to its analysis of Particular 2 above, in particular Particular 2.1 (inadequate information) and 2.3 (access to GP records), including the references given to the relevant RPS 2016 and GPhC April 2019 guidance documents, and also to the committee's analysis at Particular 5.4 in relation to Patient 10.

455. The committee is satisfied that Schedule B lists prescriptions issued by the Registrant for high-risk medicines and/or medicines requiring ongoing monitoring and that he must have done so without having access to, or seeking access to, GP or other clinical records because that was the UK Meds organisational framework within which he was prescribing.

456. His options on reviewing a patient order for medication were to 'Refuse' the request for medication, 'Refer' the order to a Clinical Lead or to 'Approve' the order. The committee is satisfied that in the context of prescribing high-risk drugs and drugs requiring ongoing monitoring as listed in Schedule B, he should have either refused or referred the order and should not have approved the order given that he did not have, and could not have, access to GP or other clinical records. The fact that he issued the prescriptions listed in Schedule B without access to GP or other clinical records means he failed to act as alleged in Particular 7.4.

457. The committee accepts that there is evidence that in other instances he did either refuse or refer patient orders to the Clinical Lead when he did not have adequate information from the patient Questionnaire.

458. **Accordingly, the committee finds Particular 7.4 proved.**

Particular 7.5 alleges the Registrant failed to request a face-to-face consultation with patients in order to examine the clinical need for medication.

459. The committee reviewed the relevant guidance and expectations placed on the Registrant in this regard in the context of Particular 2.4 and also in the context of Patient 10 at Particular 5.5.

460. The Registrant has stated that he did not seek face-to-face consultations with patients. His case is that he was able adequately to visualise patients from the information he had and that within the context of the UK Meds model, face-to-face consultations with patients were *"redundant".* The committee reviewed his approach in this regard within the context of Particulars 2.4 and 5.5 and found that his approach was inadequate. The same findings apply here.

461. The committee is satisfied that in the context of prescribing high-risk drugs and drugs requiring ongoing monitoring, he should have sought a face-to-face consultation. His alternative was to either refuse the order or refer the order to the Clinical Lead, neither of which he chose. Instead, he approved the order by issuing a prescription.

462. **Accordingly, the committee finds Particular 7.5 proved.**

Particular 7.6 alleges the Registrant failed to adequately consider the possibility of medication dependence and misuse.

463. The committee reviewed the relevant guidance and expectations placed on the Registrant in this regard in the context of Particular 2.5 and also in the context of Patient 10 at Particular 5.6.

464. The Registrant has stated that he did consider the risk of dependence. In the context of Particulars 2.5 and 5.6, the committee found that he did not do so adequately. Those same findings apply here.

465. **Accordingly, the committee finds Particular 7.6 proved.**

466. The committee returned to consider Particular 7.2.

Particular 7.2 alleges the Registrant failed to obtain adequate information in relation to the patient's health in advance of prescribing.

467. The committee reviewed the relevant guidance and expectations placed on the Registrant in this regard in the context of Particular 2.1 and also in the context of Patient 10 at Particular 5.2.

468. With regard to Particulars 7.3 to 7.6 inclusive, the committee has found the Registrant:

a. Relied principally on the patient Questionnaires,

b. Failed to seek access to GP records,

c. Failed to request a face-to-face consultation, and

d. Failed to adequately consider the issue of drug dependence.

469. Given these findings, the committee is satisfied that he failed to obtain adequate information in relation to each patient's health before issuing a prescription.

<u>Differentiated Diagnosis</u>

470. In relation to repeat prescriptions, the Registrant in his statements drew a distinction between differentiated and undifferentiated diagnosis.

471. In explaining the difference, the Registrant referred the committee to a document he provided which he indicated came from his professional indemnity insurance documents.

472. The document as presented appears to come from the Pharmacists' Defence Association (PDA) website concerned with professional indemnity insurance, 'Exclusions and Options' and appeared to have been printed on 13/5/2024. The document has a heading *"Independent Prescribing & Differentiated Diagnosis"* and *"Practicing as an independent non-medical prescriber…"*. The document references that *"Many more pharmacists are now qualifying as independent prescribers"* and

that *"Pharmacists will inherently recognise the additional risks of exposure to litigation by writing and signing prescriptions"* and:

> *"Whilst this may not be the case all the time, pharmacists will frequently be signing prescriptions in a situation which involves face to face contact with a patient and which will involve an element of diagnosis, it is this activity which leads to claims against pharmacists." And*
>
> *"The cover provided by this extension will provide indemnity for pharmacists involved in differentiated diagnosis; this is where a pharmacist assesses a patient whose condition has previously been diagnosed by a GP or other suitably qualified professional…"*

And

> *"Cover for undifferentiated diagnosis, where the pharmacist undertakes a diagnosis of a condition not previously diagnosed elsewhere, is provided by the HIGHER RISKS extension."*

473. The committee reads this to mean that a first diagnosis of a patient's condition is an *"undifferentiated diagnosis"* and pharmacist assessing a patient, for example to justify issuing a repeat prescription following an earlier prescription based on a first diagnosis, involves the pharmacist in a *"differentiated diagnosis".*

474. In response to a question from the Registrant, Ms 1 indicated that she was not aware of the two terms.

475. The Registrant's case was that when he issued a repeat prescription, he was undertaking a differentiated diagnosis and he had adequate information to do so.

476. The committee rejected his argument. In doing so, the committee noted:

a. Whether issuing a first prescription or a repeat prescription, the professional standards and guidance made clear that the prescriber is responsible for the prescription and had to be able to justify it clinically,

b. The PDA document provided was part of a larger document which the committee did not have and was therefore limited to know the context of the document, or how that context may impact on the meaning of the extract it had,

c. On one reading of the document, a pharmacist prescriber who *"assesses a patient whose condition has previously been diagnosed"* and issues a repeat prescription will be anticipated to have made the assessment during a face-to-face consultation, which was not the Registrant's practice at UK Meds. There is no reference in the document to prescriptions being issued primarily on the basis of a self-report patient Questionnaire, a practice the committee anticipates the insurers would regard as raising the risk level, and

d. Where the professional indemnity insurance document refers to assessing a patient *"whose condition has previously been diagnosed by a GP"*, the committee anticipates (in line with the professional guidance documents) that a prescriber would require accurate and reliable information to know that there had been a previous GP diagnosis, and accurate and reliable information as to the medication that had previously been prescribed and for which a repeat prescription was sought. This envisages the prescriber having access to the GP's records and a copy of a previous prescription. As recorded above, the Registrant was primarily relying on the self-report of patients as recorded in their Questionnaires. He did not access GP records.

477. On this analysis, whilst there may be a distinction in some form between undifferentiated diagnosis and differentiated diagnosis, the document does not provide a basis to justify the Registrant issuing prescriptions for high-risk drugs or drugs requiring ongoing monitoring without adequate information.

478. In the light of the above, the committee rejected the Registrant's arguments based on the reference to differentiated and undifferentiated diagnosis for the purposes of Particular 7 and all other particulars of the Allegation.

479. **Accordingly, the committee finds Particular 7.2 proved.**

Particular 7.7 alleges the Registrant failed to refer the patient back to their GP for appropriate assessment and/or review and/or monitoring.

480. The committee reviewed the relevant guidance and expectations placed on the Registrant in this regard in the context of Particular 2.6 and also in the context of Patient 10 at Particular 5.7.

481. The committee's findings in the context of Particulars 2.6 and 5.7 apply equally with regard to Particular 7.7, including:

a. That the registrant issued prescriptions for high-risk drugs and drugs requiring ongoing monitoring without contacting GPs in advance, even when consent to do so was given,

b. That having prescribed he did not share the prescribing information with the GPs, and

c. Without having done so, he could not be assured that there would be ongoing reviews and monitoring of the patients.

482. The committee notes that the evidence shows some of the patients listed in Schedule B gave consent for their GP to be contacted yet there is no evidence that prescribing information was then shared with the GPs.

483. **Accordingly, the committee finds Allegation 7.7 proved.**

Particular 7.8 alleges the Registrant failed to put adequate safety-netting in place.

484. The committee reviewed the relevant guidance and expectations placed on the Registrant in this regard in the context of Particular 2.7 and also in the context of Patient 10 at Particular 5.8.

485. The committee's findings in the context of Particulars 2.7 and 5.8 apply equally with regard to Particular 7.8, including:

a. That the registrant issued prescriptions for high-risk drugs and drugs requiring ongoing monitoring which required safety-netting to be put in place,

b. That adequate safety-netting was not put in place.

486. **Accordingly, the committee finds Allegation 7.8 proved.**

487. **Accordingly, the committee finds Particular 7 proved in its entirety.**

Particular 8

8. Your approach to prescribing in all or some of the allegations 1 to 7 was transactional in that you were processing patient requests by reference to a patient completed questionnaire rather than prescribing in accordance with UK prescribing guidance.

488. In the committee's experience, an allegation that a pharmacist was taking a *"transactional"* approach is often explicitly presented as an allegation that a pharmacist acts out of greed, with a financial motivation that over-rides a patient centred approach.

489. In this case, however, *"transactional"* is, in effect, defined on a narrow basis within the terms of Particular 8 to involve the Registrant processing patient requests for medication by reference to the patient Questionnaire rather than in accordance with relevant guidance. The terms of Particular 8 do not reference financial matters or allege greed as a motivation.

490. It is an uncontested fact that the Registrant was processing patient requests for medication by reference to patient Questionnaires completed by patients and the committee has already found as a fact that his prescribing was not in accordance with relevant guidance.

491. **Accordingly, the committee finds Particular 8 proved on this narrow basis.**

492. This finding adds little, if anything, to the substance of the allegation. It is a finding, based on the terms of Particular 8, that he was prescribing based on patient Questionnaires and not in accordance with relevant guidance as alleged in Particulars 1 to 7.

493. In submissions, both parties referred to financial matters. On behalf of the GPhC, it has been highlighted that the Registrant had the potential to earn large sums of money – in this regard the Registrant has indicated that he could have been earning

in the region of *"£20,000 per month"*. The GPhC has highlighted evidence, including from Ms 1, that indicates he was working in an organisation where the management information and monitoring of prescribers performance favoured prescriptions being issued and a potential conflict of interests arose between patient-centred care and a financial benefit to UK Meds.

494. The Registrant has rejected the suggestion that his clinical assessments were improperly motivated by financial gain. The Registrant, in his submissions, was concerned that he was being presented as someone who was *"basically selling drugs like a dealer, not concerned with patient well-being"* which he strongly disputed, and regarded as *"an insult".* He insisted that he exercised appropriate clinical judgement.

495. For clarity and for the avoidance of doubt, the committee does not find the Registrant to have acted improperly out of a financial motivation. The committee reaches this conclusion given the following:

a. There is evidence that the Registrant has consistently focused on the benefits that online pharmacies could bring to patients, opening access to health care and the provision of medicines.

b. There is substantial evidence, particularly in emails exchanges between the Registrant and those responsible for running UK Meds, that the Registrant highlighted aspects of UK Meds systems that raised patient safety concerns, and identified improvements that could be made to enhance patient safety.

c. There is also evidence that he was referring many individual patient Questionnaires to the UK Meds Clinical Lead for further review when he was concerned about patient safety, a move that meant he would not be remunerated for considering those referred patient Questionnaires.

d. The fact that he was to be well-remunerated does not, in and of itself, establish that his clinical assessments were inappropriately influenced by money. He appears to have been paid a set fee for each patient Questionnaire on which he made a prescribing decision whether he approved or refused a prescription.

e. There is good evidence in the emails that he chose to leave UK Meds, despite the potential remuneration, and that his motivation for doing so was because of patient safety concerns and/or the fact that his workload was being reduced because he was refusing orders and referring high numbers of patients to the Clinical Lead rather than simply approving patient orders.

496. Accordingly, for the avoidance of doubt, the committee does not find that his clinical work with UK Meds was inappropriately influenced in by a financial motivation. Insofar as he was financially motivated, it is no more than anyone may be who is financially motivated to take work that is well paid. There is evidence that he had patient safety and a patient-centred approach in mind albeit the committee has made findings that indicate his practices did not consistently deliver either patient safety or a proper application of a patient-centred approach.

Conclusion

497. Accordingly, the committee found all the factual particulars proved.

Stage 2: Decision on Misconduct and Impairment

498. Having found all the Particulars 1 – 8 proved, the committee must progress to the next stage of these proceedings, to determine whether a ground for impairment is established (misconduct is alleged) and whether or not the Registrant's current fitness to practise is impaired. The committee considered these matters in turn, starting with misconduct.

Decision on misconduct

499. Stage 2 of the proceedings requires the committee to first consider whether the facts as proved amount to misconduct.

500. On behalf of the GPhC, it was submitted that the factual findings of the committee concerning Particulars 1 to 8 meant that the ground of misconduct was established.

501. Given the absence of the Registrant from Stage 2 of these proceedings, the committee has, out of fairness to him, sought to take full account of the statements and documents he has provided to the committee.

502. The committee accepted the advice of the Legal Adviser.

503. When considering whether the particulars found proved amounted to misconduct the Committee took into account the 'Good Decision making: fitness to practise hearings and outcomes guidance' March 2024 (The Guidance).

504. The Committee considered whether the Registrant had breached any of the Council's Standards for Pharmacy Professionals (May 2017). The Committee determined that the following Standards had been breached:

Standard 1 - Provide person-centred care

Standard 2 - Work in partnership with others

Standard 3 - Communicate effectively

Standard 5 - Use professional judgement

Standard 8 - Speak up when they have concerns or when things go wrong

Standard 9 - Demonstrate leadership.

505. The committee reviewed each of these Standards in turn, as follows.

506. <u>Standard 1 - Provide person-centred care.</u> The expectations of pharmacists set out within this standard include the following:

• involve, support and enable every person when making decisions about their health, care and wellbeing

• listen to the person and understand their needs and what matters to them

• give the person all relevant information in a way they can understand, so they can make informed decisions and choices

• consider the impact of their practice whether or not they provide care directly

• make the best use of the resources available

507. The committee concluded that the Registrant did not meet these expectations. It reached this conclusion having regard to the following:

508. There is evidence that the Registrant had in mind person-centred care: he referred to this several times in the hearing. In particular, he expressed the view that the development of online pharmacy services enhanced person-centred care in that it improved accessibility to healthcare services.

509. However, the committee having found that whilst he had the concept of person-centred care in mind, he did not adequately understand how this would be provided in an online setting and did not consistently meet the standard expected.

510. To his credit he expressed the position that patients may not necessarily be prescribed medication just because they order it given that the prescriber makes the final clinical decision. However, he stated that his approach was to prescribe what was ordered unless he identified a reason not to do so – the committee refers to this in its Stage 1 determination above. The committee has already expressed concerns about this approach. His responsibility as prescriber was to be able to justify the issuing of a prescription, rather than finding a reason not to issue medication ordered by a patient.

511. In addition, he was prescribing high-risk medication and medication requiring ongoing monitoring without a two-way dialogue with the patient. He expressed the view that face-to-face consultations were "redundant" with UK Meds, that the patient answers to the patient Questionnaire were sufficient and "of necessity" he had to accept the answers as truthful, and that he could visualise patients comparing himself to a *"cyborg"* to achieve a clinical assessment. The committee has rejected his approach in this regard. In its Stage 1 determination it has set out why patient Questionnaire answers cannot be wholly relied upon when prescribing high-risk medication and medication requiring ongoing monitoring. The committee has concluded that in the context of UK Meds providing a prescribing service online, supplying high-risk medication and medication requiring ongoing monitoring, two-way dialogue with the patient is required to achieve patient-centred care; without a two-way dialogue he could not adequately understand *"their needs and what*

matters to them", review with patients treatment options or "support" patients to make *"decisions about their health and wellbeing"* as expected in Standard 1.

512. In addition, there is evidence of the Registrant making generalised assumptions about patients and that in doing so he was not providing individual patient-centred care. To the committee he expressed the view that if patients ordering repeat prescriptions reported having a GP then he assumed they would be engaging with the GP and the GP would be undertaking monitoring – these are flawed assumptions the starting point being the assumption that the patient was telling the truth about having a GP let alone that they were open with their GP in disclosing medication obtained online or that the GP would then be monitoring the patient. In relation to Patient 10 he assumed that as a healthcare worker Patient 10 would know about and act responsibly with regard to the risk of dependency and addiction to dihydrocodeine, and that Patient 10 would have declared if she had any issues regarding dependency and addiction – again, flawed assumptions inconsistent with providing patient-centred care.

513. Further, the Registrant could not be giving or checking that patients had *"all relevant information in a way they can understand"* given the absence of a two-way dialogue and the failures the committee has found about safety-netting.

514. He could not adequately consider the *"impact"* of his prescribing given the absence of a two-way dialogue, in particular his failure to adequately consider the risk of dependency when prescribing opioid-based painkillers or other high-risk medication and/or medication requiring ongoing monitoring.

515. He was not making the best use of resources, both generally given his failure to know and apply relevant professional guidance, and specifically with regard to patients who gave consent for their GP to be contacted. Contact with GPs could have enabled access to GP and other clinical records but he did not do this either directly or by referring, as he could have done, patient orders to the Clinical Lead to contact patient GPs.

516. The committee concludes that his enthusiasm for the development of online pharmacy services, and the opportunities as he saw it of enhancing public access to

healthcare, led him to lose sight of what patient-centred care requires, in particular that it still requires prescribers to only issue prescriptions when clinically justified based on adequate verified information.

517. Standard 2 - Work in partnership with others. The expectations of pharmacists set out within this standard include the following:

• work with the person receiving care

• identify and work with the individuals and teams who are involved in the person's care

• adapt their communication to bring about effective partnership working

• take action to safeguard people, particularly children and vulnerable adults

• make and use records of the care provided

• work with others to make sure there is continuity of care for the person concerned.

518. The committee finds that the Registrant failed to meet the expectations of Standard 2. He was not 'working with' patients, but relying on their answers to the patient Questionnaire and his belief that this gave him sufficient information to visualise patients to make clinical decisions. He was not engaging with patient GPs, or accessing GP patient medical records when consent to do so had been given, nor was he choosing the option of referring orders to the UK Meds Clinical Lead to contact patient GPs. He adapted his communication style to rely on the patient Questionnaire, undermining the required two-way dialogue with patients. He was not ensuring appropriate safety-netting was in place to protect patients as there was no follow-up care. He could not be assured of continuity of care for patients beyond the services given by UK Meds and the opportunity other UK Meds prescribers would have of reading any notes he made on the UK Meds Patient Medical Records. There was no continuity of care with patient GPs or other treating clinicians, as amply demonstrated in the case of Patient 10.

519. Standard 3 - Communicate effectively. The expectations of pharmacists set out within this standard include the following:

• adapt their communication to meet the needs of the person they are communicating with

• overcome barriers to communication

• ask questions and listen carefully to the responses, to understand the person's needs and come to a shared decision about the care they provide

• listen actively and respond to the information they receive in a timely manner

• check the person has understood the information they have been given

• communicate effectively with others involved in the care of the person

520. The committee's conclusions in this regard link to its conclusions under Standards 1 and 2 (Patient-centred care and partnership working): there was no two-way dialogue with patients involved when he was prescribing high-risk medication and/or medication requiring ongoing monitoring nor two-way dialogue with Patient GPs when consent was given. Without the two-way dialogue required to support the prescribing decisions he was taking, he could not adapt his communication style or overcome barriers that individual patients may have had to understanding their clinical condition, needs or treatment options; he could not ask patients questions nor listen to answers or check their level of understanding; he was not communicating with other clinicians involved with individual patients and could not, therefore, ensure continuity of patient care.

521. Standard 5 - Use professional judgement. The expectations of pharmacists set out within this standard include the following:

• make the care of the person their first concern and act in their best interests

• use their judgement to make clinical and professional decisions with the person or others

• have the information they need to provide appropriate care.

522. Whilst the committee has in mind that the Registrant claimed to act in the best interests of patients, he has not in fact done so given the failings it has found in his practice whilst at UK Meds. His reliance on the patient Questionnaires, without

having adequate verified information when issuing high-risk medication and/or medication requiring ongoing monitoring, was not in the best interests of patients. He has described his professional experience as an advanced clinical practitioner when prescribing within a GP practice setting, where he would have face-to-face consultations, access to medical records and was readily able to ensure safety-netting and monitoring were in place. Yet that experience did not prompt him to exercise professional judgement adequately to review critically the UK Meds prescribing model and realise its limitations.

523. Standard 8 - Speak up when they have concerns or when things go wrong and Standard 9 - Demonstrate leadership – the committee takes these two standards together since they depend on the same point.

524. The Registrant has made statements to the committee that he did raise patient safety concerns with managers at UK Meds and sought changes in practice and amendments to the patient Questionnaire. His assertions in this regard are supported by emails copies of which the committee has seen in which the Registrant has expressed to managers his concerns. His assertions are also supported by the evidence that aside from the prescriptions he did issue, he also refused and referred to the Clinical Lead some orders because he concluded he could not make a prescribing decision on the information available.

525. To some extent, therefore, he appears to have been addressing Standards 8 and 9 (speaking up/showing leadership).

526. However, the committee concludes that he did not do so adequately. He remained with UK Meds for a just under five months: whilst this may not be regarded as a very significant length of time, it was long enough for him to have issued over seven thousand prescriptions to many patients for high-risk medication and/or medication requiring ongoing monitoring, which, as reviewed below, had the potential to cause serious harm if inappropriately prescribed. This includes medicines with the potential for dependency and addiction. The committee has found that in many respects he failed to meet professional expectations and to follow guidance that supports safe and appropriate prescribing practise. He had a professional responsibility for each

prescription he issued. The experience he had of prescribing within a GP practice ought to have given him the insight to have identified the limitations of the UK Meds prescribing model and the significant patient-safety issues that arose. In these circumstances, he ought to have spoken up to a greater degree and/or left sooner and/or reported his concerns to his regulator, the GPhC, but did not do so.

527. In these circumstances, the committee finds that he did breach Standards 8 and 9.

528. Having identified several significant breaches of professional standards the committee went on to consider whether the failings and breaches identified amount to misconduct. The Committee bore in mind that the Standards may be taken into account when considering the issue of misconduct but that a breach of the Standards does not automatically result in a finding of misconduct (Rule 24(11)). It bore in mind that misconduct must be serious before it amounts to professional misconduct for the purposes of these proceedings.

529. The committee concludes that its findings regarding the Registrant are serious and amount to misconduct. It does so having taken account of the following:

a. The drugs concerned involve high-risk drugs and/or drugs requiring ongoing monitoring. Within these categories are drugs that can do significant harm if not prescribed safely and appropriately. This includes drugs that are well known for the risk of dependency and addiction such as opioid-based painkillers including dihydrocodeine, and the serious harm, both medically and socially, that can be caused when this occurs.

b. The potential for serious harm is illustrated by the circumstances of Patient 10 to whom the Registrant issued a prescription for dihydrocodeine without having adequate information: she was a patient with a significant dependency to opioid-based painkillers, poor mental health and vulnerabilities. The medicine he prescribed did not in fact reach her, but his intention was that it should do so. Had the medication reached her it is clear the medicine would have contributed to the harm she was already experiencing. Patient 10 was shortly afterwards admitted to a specialist clinic for treatment.

c. Safe and appropriate prescribing requires the prescriber to pay due regard to relevant guidance. The committee has found that he was aware of relevant guidance (such as the RPS 2016 guidance) but did not apply it appropriately in several respects. The committee has found that he was unaware of relevant guidance (such as the GPhC April 2019 guidance) but should have been aware and, being unaware, did not apply it in several respects.

d. Safe and appropriate prescribing requires the prescriber to have adequate information. The committee has concluded that the Registrant was, in a number of respects, prescribing without adequate information.

e. Safe and appropriate prescribing would also require appropriate follow-up assessment/review/monitoring to be in place along with adequate safety-netting. The committee has found that the Registrant did not do so.

f. Safe and appropriate prescribing, particularly with regard to high-risk medicines and/or medicines that require ongoing monitoring, requires continuity of care. The Registrant could not be assured that there was continuity of care.

g. The facts involve over seven thousand prescriptions issued by the Registrant for such drugs, affecting many patients, over the time that he worked there.

h. The committee has identified a number of serious concerns regarding the Registrant's practise when working for UK Meds, including:

    i. Concern regarding his understanding of patient-centred care and his approach to prescribing, namely, to prescribe unless he identified a reason not to do so when he is professionally required to identify a justification for prescribing, even with repeat prescriptions;

    ii. Concern regarding his adoption of his own framework for assessing risk to patients when prescribing, a framework that was not consistent with the frameworks set out in professional guidance, including the GPhC April 2019 guidance; and

    iii. Concern regarding his approach to assessing what were, and were not, high-risk drugs. He stated to the committee that he did not prescribe

high-risk drugs. He described paracetamol as being a higher-risk drug than dihydrocodeine, even though the statutory framework categorises dihydrocodeine as a Controlled Drug and does not do so for paracetamol. He described how water could be regarded as high-risk.

iv. Concern regarding his view that "of necessity" he had to accept the answers given in patient Questionnaires as accurate and truthful, sufficient on which to base a prescribing decision, and relying on what he described as his ability to visualise patients before him as if he was a "cyborg" as he described it, rendering face-to-face consultation as "redundant" at UK Meds, rather than realising the limitations of self-reported and unverified information from patients and the limitations of prescribing without a two-way dialogue.

530. The committee acknowledges that online prescribing was a relatively new facility, and the Registrant had not previously undertaken online prescribing. However, the principals that underpin prescribing are universal and apply whether prescribing online or in a traditional clinical setting. At their core, the universal principles require the prescriber to have adequate reliable, verified, information to justify the prescription and to ensure that appropriate follow-up review, monitoring and safety-netting is in place. The importance of adhering to the universal principles, expressed in the relevant professional guidance, is all the more important when it comes to prescribing high-risk drugs and/or drugs requiring ongoing monitoring.

531. **Given the above analysis, the Committee concluded that, in its judgement, the ground of misconduct is established.**

532. The Committee therefore went on to consider whether the Registrant's fitness to practise is impaired.

Decision on Impairment

533. On behalf of the GPhC, it was submitted that the factual findings of the committee regarding Particulars 1 to 8 meant that not only was misconduct established but that

the committee should also conclude the Registrant's fitness to practise is currently impaired. The committee was referred to the four factors in Rule 5(2): on behalf of the GPhC reliance was placed on the first three factors (risk to the public, causing the profession disrepute and breaching a fundamental principle of the profession).

534. The GPhC did not rely on the fourth factor, namely a lack of integrity.

535. Given the absence of the Registrant from Stage 2 of these proceedings, the committee has, out of fairness to him, sought to take full account of the statements and documents he has provided to the committee.

536. The committee accepted the advice of the Legal Adviser.

537. When considering whether the Registrant's fitness to practise is currently impaired, the committee had regard to its statutory overarching objectives, to Rule 5(4) which identifies factors it should take into account, and also to the GPhC March 2024 Guidance.

538. Accordingly, when considering current impairment, the committee considered whether he presents a risk to the public, and/or a risk to public confidence in the profession, and/or a risk to maintaining professional standards.

539. The committee first considered the Registrant's insight into his failings, by which it means his understanding of having done wrong, how it occurred, and the impact it would have.

540. In this regard, the committee has placed significant consideration on his denial of the Allegation in its totality and the robustness with which he defended the matter at Stage 1. His statements to the committee included strong approval for the UK Meds model as improving access to healthcare. He said on several occasions that his approach was patient-centred, that he did not prescribe "high-risk" medication, and justified the prescriptions he issued including those which were for repeat prescriptions. He argued that the UK Meds prescribing model made face-to-face consultations *"redundant"*, justified his prescribing practise even when there was no contact with GPs either before or after prescribing, and prescribing without having sight of GP patient medical records. With regard to Patient 10, he sought to justify

the prescription for dihydrocodeine he had issued and was very critical of Patient 10's GP for issuing a prescription for the same medication days later. He claimed to have been compliant with the RPS 2016 guidance that he was aware of, and he minimised and excused the fact that he was unaware of the GPhC April 2019 guidance for most of the time he worked with UK Meds. In his email of 24/9/2024 he described expecting *"complete exoneration and vindication"*: the committee is concerned by this since it suggests that he continues to believe he has done no wrong.

541. Given this background, the committee could readily conclude that he had little to no insight into his failings.

542. However, it is right to record that the Registrant also made statements during the hearing to the effect that he no-longer supported the use of the UK Meds model for prescribing dihydrocodeine and other high-risk drugs, and he expressly acknowledged that had he known what he knows now about Patient 10 he would not have issued a prescription to her. This suggests that despite the very defensive posture he adopted at Stage 1 he in fact has some understanding that what occurred was not right.

543. The committee acknowledges that on his account he has substantial experience of prescribing within the context of a GP practice. The committee also acknowledges that, based on his statements to the committee and contemporaneous emails, he had patient safety and a patient-centred approach in mind when working at UK Meds, albeit in the committee's judgement he did not then consistently deliver these aspects of prescribing. The committee also notes that he was not inappropriately financially motivated to issue prescriptions.

544. Assessing the Registrant's insight is complicated by the inconsistencies in his statements. These having included expressing approval for the UK Meds prescribing model to then stating that he now thinks that dihydrocodeine and other medicines should not be prescribed online; describing the UK Meds patient Questionnaire as the best he had seen rendering face-to-face consultation *"redundant"* whilst also identifying weaknesses in the patient Questionnaire which he sought to address while working at UK Meds; statements criticising Patient 10's GP for issuing a

prescription without knowing about the prescription he, the Registrant, had issued days earlier, while defending his decision to issue Patient 10 with a prescription for dihydrocodeine without knowing what her GP had previously prescribed for her.

545. The Registrant has not attended the Stage 2 part of the hearing when the committee might have been able to further explore the degree of insight he has into his misconduct.

546. On balance, the committee finds that there is evidence of some insight but that at best it can only be regarded as limited insight falling far short, on the available evidence, of full insight.

547. The committee has gone on to consider what steps he has taken to address the identified failings. In this regard, the committee has had regard to his attitudinal failings, in particular:

a. his misunderstanding of what is required with patient-centred care;

b. his attitude of prescribing unless he identified a reason not to do so when the professional requirement is to identify a clinical justification to prescribe;

c. his attitude regarding his ability to make safe and appropriate prescribing decisions based on the patient Questionnaire, his ability, as he describes it, of visualising patients and his view that the need to see patients face-to-face was rendered “redundant” by the UK Meds patient Questionnaire;

d. his attitude to assessing risk associated with prescribing in general by his use of his own risk framework that is not in line with professional guidance;

e. his attitude towards what are and are not high-risk drugs that is not in line with professional guidance;

f. his attitude of basing clinical decisions on assumptions about patients, such as assuming patients with GPs were subject to monitoring; and

g. that his approach to issuing repeat prescriptions was out of line with professional guidance that required each prescription to be clinically justified.

548. The committee has no evidence that he has taken steps to address these attitudinal failings. For example, there is no evidence that he has undertaken relevant training, or reflective practice to contemplate what needs to change in his practise, or engage with a mentor to discuss what has occurred and what ought to change in the future. The committee has very little independent and verified information regarding his more recent prescribing practise within a GP practice setting.

549. Accordingly, the committee finds that there is no significant evidence of him remediating his attitudinal failings.

550. The committee has found that his prescribing practise when at UK Meds had the potential for causing serious harm given that he was not making safe or appropriate decisions when prescribing high-risk medicines and/or medicines that require ongoing monitoring.

551. In the absence of evidence to show that he has addressed these attitudinal failings, the committee can only conclude that were he to again engage in prescribing in an online setting, there is a risk that he would repeat the failings that have led to a finding of misconduct.

552. Given the nature of the failings and the committee's findings, the committee therefore finds that he presents a risk of serious harm to members of the public. The seriousness of that potential harm is illustrated by reference to Patient 10.

553. **Accordingly, the committee finds the Registrant's fitness to practise to be impaired given that he presents a risk of causing harm to members of the public.**

554. The committee is also satisfied that his misconduct brings the profession into disrepute and thereby undermines public confidence. Pharmacists hold a trusted role within society, acting as gatekeepers by managing the release of medicines into the community when medicines can do good, knowing that if prescribed inappropriately medicines can cause serious harm. The Registrant has broken that trust. He has, on multiple occasions, prescribed drugs, expecting them to then be dispensed, when he has not been able to make safe and appropriate clinical decisions.

555. There is a particular significant public concern regarding drugs that lead to dependency and addiction, most especially regarding opioid-based painkillers such as dihydrocodeine. The Registrant's breach of trust is particularly acute given that he was prescribing on multiple occasions, including to Patient 10, opioid-based medicines without a safe and appropriate prescribing decision. The scale of the Registrant's prescribing would be of very significant public concern given the nature of the high-risk drugs involved and the potential serious harm that could be caused to individuals, families and communities as a result of dependency and addiction.

556. The public would be similarly concerned with medication being prescribed that requires ongoing monitoring to ensure patient safety when that monitoring is not put in place.

557. In addition to the adverse impact on public confidence in the profession caused by his misconduct, the committee is satisfied that public confidence would be further undermined if there was no finding of impairment given its conclusion that he presents a risk of repeating the misconduct and the consequential potential for future harm.

558. The message to the public must be clear that misconduct such as that by the Registrant is regarded as serious. This necessitates a finding of impairment.

559. **Accordingly, the committee finds that there must be a finding of current impairment to promote public confidence in the profession.**

560. The committee is also clear that the Registrant has breached a fundamental principle of the profession requiring practise to be patient-centred with safe and appropriate prescribing decisions. The committee is satisfied that other members of the profession would regard the misconduct as falling far short of what is expected given the Registrant's approach to prescribing and the serious consequences that may flow when high-risk medicines and/or medicines requiring ongoing monitoring are prescribed other than in a safe and appropriate manner. The committee is satisfied that the misconduct is so serious that there must be a finding of impairment to uphold professional standards. The committee is satisfied that professional standards would be undermined were there not to be a finding of impairment.

561. The committee concluded that there must be a clear message to other members of the profession, namely that pharmacist prescribers are responsible for each prescription they issue, that pharmacist prescribers have a responsibility to exercise professional scepticism and inquiry when assessing patients to ensure that clinical decisions to issue prescriptions are justified on the basis of adequate reliable and verified information, and to ensure appropriate monitoring and safety-netting is in place, and prescribing is in accordance with relevant professional guidance and standards.

562. The committee makes it clear that it finds the Registrant's misconduct to be so serious that there should be a finding of impairment irrespective of his otherwise previously unblemished record.

563. In reaching this conclusion the committee acknowledges, as the Registrant pointed out in the hearing, that there were other pharmacists prescribing at UK Meds and that no-one raised concerns or objected. The Registrant also pointed to the fact that the regulator allowed UK Meds to continue despite knowing the nature of the UK Meds prescribing model, in particular the reliance on a patient Questionnaire. The committee has limited information regarding who else was prescribing and the circumstances on which they were prescribing. The committee's focus has been to assess the Registrant's practise. In any event, whatever other pharmacists who worked at UK Meds may have thought, the committee is satisfied that the wider body of pharmacists would find the practice adopted by the Registrant at UK Meds as deplorable given that high-risk medication and/or medication requiring ongoing monitoring was prescribed with inadequate information to justify a clinical decision and outside of professional guidance. In its Stage 1 determination, the committee acknowledged with some sympathy the Registrant's submissions regarding the regulator but also identified his personal professional responsibility to ensure each prescription was clinically justified, and the advantage of his advanced clinical practitioner experience should have led him not to prescribe in the way he did with UK Meds.

564. **Accordingly, the committee finds that there must be a finding of impairment in order to promote professional standards.**

Conclusion

565. Having found the Registrant's fitness to practise to be currently impaired, the Committee therefore went on to consider Stage 3 pf these proceedings, namely the issue of sanction/outcome. Before doing so, the committee dealt with the existing Interim Order.

Interim Order

566. As had become apparent during the hearing, the Registrant has been and remained subject to an interim order of Conditions.

567. Having found impairment, and as required by the Rules, **the committee revoked the Interim Order.**

Stage 3: Decision on Sanction/Outcome

568. Having found impairment, the committee has gone on to consider the matter of 'sanction' as it is referred to in the Rules, 'outcome' as it is now referred to in the GPhC Good decision making guidance of March 2024.

569. The committee's powers are set out in Article 54(2) of the Order. The committee should consider the available sanctions in ascending order from least restrictive, take no action, to most restrictive, removal from the Register, in order to identify the appropriate and proportionate sanction that meets the circumstances of the case.

570. The purpose of the sanction is not to be punitive, though a sanction may in fact have a punitive effect. The purpose of the sanction is to meet the overarching objectives of regulation, namely the protection of the public, the maintenance of public confidence and to promote professional standards. The committee is therefore entitled to give greater weight to the public interest over the Registrant's interests.

571. The committee had regard to the GPhC's 'Good decision making: Fitness to practise hearings and outcomes guidance' of March 2024 to inform its decision.

572. The committee took into account the submissions made on behalf of the GPhC. It was the GPhC's submission that the appropriate sanction was of removal.

573. Given the absence of the Registrant from Stage 3 of these proceedings, the committee has, out of fairness to him, sought to take full account of the statements and documents he has provided.

574. The committee accepted the advice of the Legal Adviser.

575. The committee first considered what, if any, aggravating and mitigating factors there may be.

576. The committee identified aggravating factors, including the following.

a. The nature of the medication for which he has issued prescriptions, namely high-risk medicines and/or medicines requiring ongoing monitoring. They consisted entirely of Prescription Only Medicines ('POMs'). They included Controlled Drugs of Schedules 3, 4 and 5 including drugs liable to abuse, misuse or overuse, including addictive properties, for example, opioid-based painkillers. The prescriptions also included POMs that were not Controlled Drugs but considered high-risk because of the potential for serious side-effects and the risk of toxicity. The prescriptions also included other drugs which, though not necessarily habit-forming or liable to abuse, misuse or overuse, had the potential for presenting a risk to patients for a number of reasons, and required, for example, the need for ongoing monitoring in order to maintain patient safety.

b. The number of prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring issued being "a least 7,684" which the committee regards as a very substantial and significant number, representing many patients affected by the Registrant's prescribing practise.

c. Of these prescriptions, a significant number were for repeat prescriptions when the Registrant was issuing a prescription to patients who had already received earlier prescriptions, sometimes many prescriptions over many months.

d. The degree of risk of harm that emerges from his prescribing practise. The committee is particularly concerned with the prescriptions issued for opioid-based painkillers that risked dependency and addiction. The harm that can then follow, to patients, their families and to society more widely, can be very serious given the use of opioid-based painkillers may lead to dependency and addiction. The circumstances of Patient 10 illustrate the very significant public concern that rightly arises from the Registrant's practise of prescribing such medication without adequate patient and clinical information or appropriate safe-guards including safety-netting. The committee's concerns extend beyond the opioid-based painkillers but to all the high-risk drugs given the risk of harm that they carry. The committee is similarly concerned with the medicines prescribed requiring ongoing monitoring to ensure patient safety: ongoing monitoring arrangements were not clearly in place giving rise to a significant risk of serious harm to patients.

e. That there were a range of failings in the Registrant's process of prescribing. This included his reliance on self-report patient Questionnaires, the absence of face-to-face consultation, the absence of access to appropriate clinical records, the failure to consider the risk of dependence or misuse, and the failure to ensure continuity of care through appropriate review, monitoring and safety-netting.

f. Given the range of failings referred to above, there was no effective assessment of patient vulnerabilities and therefore no mitigation against the risk of harm that could come to vulnerable patients.

g. That this misconduct was not momentary but was repeated over a period of nearly five months.

h. The failure to be aware of, or comply with, relevant guidance documents including guidance issued by the Registrant's own professional body and by his regulatory body.

i. The number of professional standards breached – the committee has identified wide-ranging breaches of six standards out of the nine standards set by the regulator.

j. Allied to the breaches of standards, the circumstances of the case are aggravated by the committee's concerns regarding the Registrant's attitudinal failings, including the following.

k. His failure to deliver patient-centred care: he depersonalised patients by relying on patient Questionnaires, without engaging with patients in two-way dialogue; by his belief that face-to-face consultations were "redundant" and his belief in his ability to visualise patients like a "cyborg" in order to conduct a clinical assessment of them; and by his making of assumptions about patients.

l. His attitude of prescribing medication unless he identified a reason not to do so, rather than understanding his professional responsibility to justify each prescription he issued, including in the context of repeat prescriptions.

m. His attitude to applying his own approach to risk, including assessing the risk that different drugs presented and patient risk, approaches that were out of line with professional guidance.

n. His inadequate insight. The committee is concerned by his inadequate insight. His inadequate insight emerges particularly from his attitudinal failings that signal an attitude that he 'knows best' and his attitude that he did no wrong. These attitudes were sustained throughout Stage 1 when the Registrant robustly defended himself against the allegations and maintained he knew what he was doing, and has been sustained into more recent communications from him when he has expressed an anticipation of being "exonerated". It is now five years since the events of this case: it is of concern that over that time the Registrant has not been able to reflect to the point that he could accept a degree of responsibility and accountability for what occurred. Indeed, it is an aggravating feature that rather than accept his professional responsibility, he has pointed blame at the GPhC and other professionals including Patient 10's GP. Given the extent of his attitudinal failings and the concerns regarding his insight, the committee concludes that he has shown entrenched poor professional and clinical judgement.

577. The committee concludes that these aggravating features make the circumstances of the case very serious. When taken together, these aggravating features highlight the sheer scale of the Registrant's misconduct and impairment, as reflected in the nature of medicines prescribed, the number of prescriptions issued, and risk of very serious harm.

578. The aggravating features are underscored by the Registrant's experience as a pharmacist prescriber at the level of an advanced clinical practitioner. He was not a novice. On his account, he had considerable experience prescribing within a GP practice when he frequently and routinely saw patients face-to-face, had ready access to patient GP medical records, and could readily ensure continuity of care with other healthcare professionals within the GP practice. The absence of these features at UK Meds put patient safety at risk and should have been very apparent to him, sufficient to have caused him to hold back from prescribing. The core principles for safe and appropriate prescribing are universal. His failure to carry these universal principles over from his traditional GP practice setting into the online setting is an aggravating feature given his experience.

579. The Committee identified mitigating features including the following.

a. His professional past work including that of being a pharmacist prescriber working within a GP practice both before he worked at UK Meds and subsequently, over which time no concerns have been reported against him to the regulator. The committee has limited information about his past practise including at the GP practice. What information it has has emerged in his statements to the committee during Stage 1 and the documentation he provided. The documentation includes a substantial amount of written reflective learning written by him, and some documents he has written following peer review. His documentation also includes a review of his work against the RPS Competency Framework undertaken in December 2023 by the GP with whom he worked: the review contains little narrative by the GP beyond writing "Yes" against nearly all of the competencies. What information the committee has suggests that the concerns and failings identified by the committee in his online practise did not emerge in his practise at the GP practice. For example, his documentation

includes a detailed reflective report expressing his concern about patients who had been on an opioid-based pain-killer for more than three months, and steps he took within the GP practice to identify such patients, review their medication, and move them on to alternative medication with ongoing monitoring and review. The document is not dated but the Registrant's statement to the committee was that it was written within the past five years. The committee has not had the opportunity of hearing sworn evidence from professionals working with the Registrant to report on his prescribing practise within the traditional setting.

b. His oral statements to the committee acknowledging that he would not prescribe in such a way again or if he had known what he knows now particularly in relation to Patient 10. The committee reviewed this when assessing his level of insight. His statements suggest he has some understanding that what occurred was wrong. However, despite the committee questioning the Registrant, his motives for his statements remain somewhat unclear, particularly whether he now realises what he did was wrong or whether he simply now anticipates that such actions can result in regulatory action. As with assessing his insight, the committee's task in assessing mitigation is complicated by his inconsistent statements. For example, his documentation includes a letter written by the Registrant to the Professional Standards Authority dated 7/1/2024 in which he complains about the conduct of the GPhC but also writes "I fully accept the role I inadvertently played …within the now discredited Questionnaire-based Online Prescribing Platform…and I fully accept the need for…some form of sanction", a statement that contradicts the defensive line he adopted at Stage 1, justifying his actions and commending the UK Meds patient Questionnaire.

c. He left UK Meds after nearly 5 months. There is evidence that whilst he worked at UK Meds he raised with UK Meds concerns regarding patient-safety and proposed improvements to the patient Questionnaire: emails seen by the committee evidence his actions in this regard. Ultimately, he chose to leave UK Meds despite the fact that he thereby lost the opportunity to earn substantial sums of money. There is evidence that before leaving, the rate at which he

refused or referred patient prescriptions to the Clinical Leads increased, suggestive of his concerns about patient safety, albeit he continued to issue prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring up to the time he left. This increased rate of refusing and referring led him to receiving less work from UK Meds. Whether he left UK Meds primarily because of the reduction in work allocated to him or because of his patient safety concerns is less than clear, but the committee gives him the benefit of a degree of mitigation given that he did in fact leave UK Meds.

580. Before concluding its review of aggravating and mitigating factors, the committee makes the following two observations.

a. No financial motive: the committee concluded at Stage 1 that the Registrant was not inappropriately financially motivated in his actions. Whilst an inappropriate financial motivation would amount to an aggravating feature, its absence does not amount to a mitigating feature.

b. No evidence of actual harm: Patient 10 suffered harm as a result of her dependency on opioid-based painkillers. Prescriptions she received for such drugs would have perpetuated that harm. As it is, the prescription the Registrant issued to Patient 10 for Dihydrocodeine did not reach her, though this was not through any action of the Registrant whose intention was that she should receive the prescription. Accordingly, whilst it cannot be said that the Registrant caused actual harm as an aggravating feature, the committee is not minded to find the absence of actual harm a mitigating feature. The risk of serious harm being caused by the Registrant's issuing of thousands of prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring gave rise to a very significant risk of serious harm and this is counted as an aggravating feature.

581. Having considered the aggravating and mitigating factors, the committee has gone on to consider its options with regard to sanction, starting from the least restrictive outcome.

582. <u>To take no action.</u> The committee was satisfied that this option would not be appropriate. The committee has identified the Registrant as representing a risk of

causing harm to others. That risk would be unaddressed if the committee took no further action.

583. Warning. The committee was satisfied that this option would not be appropriate. The committee has identified the Registrant as representing a risk of causing harm to others. That risk would be unaddressed if the committee issued a warning. In addition, the committee took the view that the Registrant's misconduct is of a very serious nature: he issued a very large number of prescriptions for high-risk medicines and/or medicines requiring ongoing monitoring without adequate information and appropriate safe-guards in place over an extended period of time. The drugs prescribed risked causing serious harm to others. A warning would not reflect the seriousness of what occurred and would not therefore be sufficient to maintain public confidence or promote professional standards.

584. Conditions of Registration. The committee next considered the imposition of conditions of registration. A conditions of registration Order would allow the Registrant to practise albeit with restrictions. The committee must determine whether a conditions of registration would be appropriate given the concerns identified regarding the Registrant's practise, in particular whether conditions would protect the public from harm, be sufficient to mark the seriousness of the matter so as to maintain public confidence in the Registrant, the profession and the regulator, and sufficient to promote professional standards within the profession.

585. If conditions are to be imposed, the conditions must be relevant and proportionate to the concerns identified regarding the Registrant's practise. Conditions must be workable and are capable of being monitored. The committee must also be satisfied that the Registrant will comply with any conditions imposed.

586. The committee was satisfied that this option would not be appropriate. The committee has identified the Registrant as representing a risk of causing harm to others. That risk may, in principle, be capable of being addressed by conditions, though this is not clear. The committee has considered whether it would be possible to identify conditions to manage risk of harm by restricting the nature of his practise. The role of pharmacists has advanced from having the professional responsibility and

accountability for dispensing and clinically checking prescriptions to now prescribing, thus offering the options to restrict particular features of the role by imposing conditions. Additionally, settings within which pharmaceutical care can be provided have also increased, which offers options for restrictions in practice settings. The Registrant has practised in three roles, namely as a pharmacist dispensing medication, a pharmacist prescriber within a traditional setting of a GP practise, and a pharmacist prescriber within the an online setting. Conditions could bar him from one or more of these roles/settings. However, the concerns identified by the committee bring into question his professional and clinical judgement and attitudes that impact on his ability to practise as an online prescriber, but which may well impact on his ability to practise more generally. In these circumstances, the committee was not satisfied that conditions could be identified that would manage the risk of harm without, for example, involving an unworkable level of supervision and in any event would not be likely to address his poor judgement and attitudinal issues.

587. In any event, the committee takes the view that the misconduct and impairment found is so serious that a conditions of registration Order would not send a clear enough message to either maintain public confidence or to promote professional standards. In reaching this conclusion the committee has had in mind that the Registrant issued thousands of prescriptions for high-risk medication and/or medication requiring ongoing monitoring when he had inadequate information and no safe-guards in place. The medicines he prescribed risked causing serious harm to patients. In so doing he breached fundamental tenets of being a pharmacist, namely to put the best interests of patients first and to be the gate-keeper of medicines.

588. In addition, in the absence of the Registrant, who has disengaged from these proceedings, the committee cannot be confident that he would engage and comply with any conditions that were imposed.

589. Accordingly, the committee concluded that a conditions of practice order was not appropriate in this case.

590. Suspension Order. The committee next considered whether suspension would be a proportionate sanction. The committee noted the GPhC's guidance which indicates that suspension may be appropriate where:

> *"The Committee considers that a warning or conditions are insufficient to deal with any risk to patient safety or to protect the public, or would undermine public confidence.*
>
> *When it is necessary to highlight to the profession and to the public that the conduct of the professional is unacceptable and unbefitting a member of the pharmacy profession. Also, when public confidence in the profession demands no lesser outcome."*

591. The panel acknowledges that a suspension order would, for the duration of the order, protect the public from the risk the Registrant presents to the public. The committee's concern is that the Registrant's failings are indicative of entrenched attitudinal failings that are significant and contradictory to his ability to practise safely. He stoutly maintained that he had done no wrong throughout Stage 1 and sustained this into his later communications when he expressed his anticipation of being "exonerated". There is no substantive evidence before the committee that his stance is likely to change. There is, for example, no evidence that he has reflected on his conduct at UK Meds in any meaningful way over the five years since he worked there, nor reflected on the committee's findings of fact since they were determined, expressed limited remorse or apology for what occurred. The panel further takes the view that given the range and depth of his attitudinal failings, the breach of fundamental tenets, and the lack of taking professional responsibility and accountability, there is no evidence to suggest that even over the period of a twelve month suspension these failings would be remediated. In addition, the committee is not assured that a period of twelve months' suspension would be sufficient to reflect the seriousness of the Registrant's failings in a way that would maintain public confidence or promote professional standards.

592. For all these reasons, the committee concluded that even a maximum period of twelve months suspension would not be appropriate.

593. Removal. Given the above conclusions, and taking account of the seriousness of the matter, the committee concluded that the appropriate and proportionate sanction was of removal. The committee has set out above that it concludes the aggravating features make the circumstances of the case very serious and that when taken together, the aggravating features highlight the sheer scale of the Registrant's misconduct and impairment. This is reflected in the nature of the medicines prescribed, number of prescriptions issued, and risk of very serious harm, his attitudinal failings, and the number of professional standards he breached. The committee is satisfied that the findings of the committee mean that the Registrant's behaviour was fundamentally incompatible with being a pharmacist. The committee is satisfied that no lesser sanction is appropriate. The committee is satisfied that removal is required in the public interest, to protect the public, to ensure that the appropriate messages are clear to maintain public confidence and to promote professional standards.

594. The message to the public must be clear, namely that the interests of patients must be paramount and applied in line with professional standards and professional guidance if patients are to be cared for safely and appropriately. This is particularly when prescribing high-risk medicines and/or medicines requiring ongoing monitoring to ensure medicines are prescribed safely and appropriately to avoid serious harm being suffered.

595. The message to other members of the profession must be similarly clear. Pharmacist prescribers are responsible and accountable for each prescription they issue regardless of the setting in which care is delivered, or whether NHS or private. Pharmacist prescribers have a responsibility to exercise professional scepticism and inquiry when assessing patients to ensure that clinical decisions to issue prescriptions are justified. The justification for prescribing must be on the basis of adequate reliable and verified information, and to ensure appropriate monitoring and safety-netting is in place, and prescribing is in accordance with relevant professional guidance and standards. Whilst being a member of the pharmacy profession may bring many benefits, it also brings with it personal responsibility and accountability for prescribing decisions. This message is particularly important since it is anticipated

that in the near future each pharmacist, no matter whether inexperienced or highly experienced, will be authorised to issue prescriptions.

596. **The Committee therefore directs that the Registrar remove the name of Mr Mobolaji Adeyinka Onafuwa from the register.**

597. In reaching this conclusion the committee has taken full account of the Registrant's representations, the mitigating features and the Registrant's own interests, including his interest in pursuing the profession of his choice. However, the committee is satisfied that the public interest in directing removal outweighs those matters given the seriousness of the circumstances.

598. In particular, the committee has taken account of the Registrant's argument that he should not be held to account when, in his view, the failure was that of the GPhC for allowing UK Meds to operate; as he argues, had the GPhC stopped UK Meds from operating he would not have worked for it. In Stage 1 the committee expressed some sympathy with the Registrant. The committee takes this opportunity to make clear that in expressing sympathy it indicates its understanding for why the Registrant might raise such an argument but, as indicated earlier, the committee neither has the remit nor the evidence on which it could express a view about the merits or otherwise of the argument. The committee's role and remit has been to focus on the Registrant, his actions and his personal professional responsibilities and accountability.

599. In addition, this is an opportunity to remind pharmacists of the professional standard that expects pharmacists to report concerns, particularly patient safety concerns. Reporting concerns is integral to a proportionate and effective regulatory system that supports good pharmacists and protects patients. **The pharmacist who cared for Patient 10 reported their concerns about UK Meds to the GPhC and is to be commended for doing so.**

Decision on Interim Measure

600. The committee's decision on sanction will not take effect until 28 days after notice of this decision has been sent, or until a final disposal of any appeal against that decision. Over that period, the Registrant would be able to practise unrestricted given that the Interim Order has now been revoked unless further action is taken by way of an Interim Measure.

601. Interim Measures are provided for under Article 60 of the Order to cover the period between the end of the Principal Hearing and the coming into effect of the substantive decision whether after the 28 day period or after an appeal.

602. Interim Measures may only be imposed on the basis of one or more specified grounds, namely that the Interim Measure is:

a. necessary to protect the public, and/or

b. otherwise in the public interest, and/or

c. in the interests of the Registrant.

603. Interim Measures may only be imposed after an order for removal, suspension or conditions of registration.

604. If an Interim Measure is to be imposed it may be for conditions of registration or suspension.

605. In light of the committee's finding, the GPhC applied for an Interim Measure of suspension.

606. The committee received and accepted the advice of the legal adviser.

607. The committee took account of the GPhC's guidance of March 2024.

608. The committee determined to grant the application and to impose an Interim Measure of suspension. It did so on the basis that it is necessary to protect the public and otherwise in the public interest.

609. The committee reached this conclusion given its finding that the Registrant presents a risk of causing serious harm to others, the risk of repetition that the committee has

identified, and the seriousness of the failings identified by the committee. If no Interim Measure is imposed, the public would be at risk of harm and public confidence would be undermined.

610. The committee is satisfied that conditions could not be formulated to meet the risk and, in any event, would not be sufficient to maintain public confidence.

611. **Accordingly, the Committee orders an Interim Measure of Suspension be imposed on the Registrant.**

612. This concludes the determination.