PUBLIC RECORD

Dates: 21/07/2025 - 05/08/2025

Doctor:	Dr Anthony SHONDE
GMC reference number:	4199542
Primary medical qualification:	MB BS 1995 University of London

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

Summary of outcome

Suspension, 9 months.

Tribunal:

Legally Qualified Chair	Mr Gerry Wareham
Lay Tribunal Member:	Dame Nicola Stephenson
Registrant Tribunal Member:	Dr Juliet Bennett

Tribunal Clerk:	Mr John Poole

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Christopher Gillespie, Counsel, instructed by the Medical Protection Society.
GMC Representative:	Mr Hugh Barton, Counsel, instructed by GMC Legal

Attendance of Press / Public

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

Overarching Objective

Throughout the decision making process the tribunal has borne in mind the statutory overarching objective as set out in s1 Medical Act 1983 (the 1983 Act) to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 30/07/2025

Background

1. Dr Shonde qualified in 1995 from the University of London and went on to specialise in internal medicine and gastroenterology. Since January 2009 he has been working as a Consultant Gastroenterologist at Sherwood Forest Hospitals NHS Foundation Trust ('the Trust') in Nottingham. At the time of the events that are the subject of this hearing, Dr Shonde was assisting an online pharmacy, Letter Box Meds ('LBM'). Dr Shonde had become involved with LBM after being approached by one of its directors in 2019. He agreed to assist with the development of the clinical protocols for the online pharmacy without remuneration.

2. It is alleged that between February 2020 and April 2020 whilst working for LBM, Dr Shonde issued in excess of 1,000 prescriptions, and on one or more occasion, including for one or more of those prescriptions, failed to obtain an adequate clinical history of the patient prior to prescribing the medication by physically examining the patient, discussing the patient's case with their GP, or accessing and reviewing the patient's medical records. Further, it is also alleged that Dr Shonde inappropriately prescribed medication for a number of patients, which included prescribing opioids when there was insufficient evidence or clinical reason to do so.

3. The initial concerns were raised with the GMC on 27 April 2020 via a referral from Ms A, an inspector employed by the General Pharmaceutical Council (GPhC').

4. Ms A had inspected LBM to ensure that they met the required standards for registered pharmacies. In summary, she found numerous failures, including that LBM did not have in place the correct risk assessment in relation to prescription of high-risk medicines. Following her findings, Ms A referred Dr Shonde to the GMC as he had been a prescriber for LBM and the clinical lead.

5. The GMC opened an investigation into allegations that Dr Shonde had inappropriately or irresponsibly prescribed high risk medicines, including opioids, without adequate risk management and safeguarding in place.

The Outcome of Applications Made during the Facts Stage

6. The Tribunal granted an application made on behalf of the GMC pursuant to Rule 17(2) of the General Medical Council (Fitness to Practise Rules) 2004 as amended ('the Rules'), to amend the Allegation. The application was not opposed, and parties provided an agreed copy of the amended Allegation. The Tribunal was satisfied that the amendment could be made fairly and without injustice to either party, it therefore granted the application.

7. The Tribunal refused an application made by Mr Gillespie at the close of the GMC case, on behalf of Dr Shonde, in pursuant to Rule17(2)g. The application was opposed by Mr Barton on behalf of the GMC. The Tribunals determination can be found at Annex A.

The Allegation and the Doctor's Response

8. The Allegation made against Dr Shonde is as follows:

1. Between February 2020 and April 2020, whilst working for Letter Box Meds, you issued in excess of 1,000 prescriptions, and on one or more occasion, including for one or more of the prescriptions set out in Schedule 1, you failed to obtain an adequate clinical history of the patient prior to prescribing the medication by either:
    a. physically seeing and/or examining the patient yourself; **Admitted and found proved**
    b. discussing the patient's case with their GP; **Admitted and found proved**
    c. accessing the patient's medical records; or **Admitted and found proved**
    d. reviewing the patient's medical records to ascertain whether the patient required a physical examination. **Admitted and found proved**

2. On 21 February 2020 you issued a prescription for dihydrocodeine to Patient D for the concerns set out in Schedule 2, which was inappropriate as you:
    a. failed to ensure that Patient D was examined in person given that they did not appear to have a current GP and therefore:
        i. needed an updated assessment of their pain; **To be determined**

ii. may have needed a referral to orthopaedics or physiotherapy. To be determined

3. On 26 February 2020 you issued a prescription for co-codamol to Patient F for the concerns set out in Schedule 3, which was inappropriate as you failed to review Patient F's medical records to decide whether they required a physical examination to exclude other pathology. To be determined

4. On 6 March 2020 you issued a prescription for codeine and zapain to Patient G for the concerns set out in Schedule 4, which was inappropriate as you:

a. failed to ensure that Patient G was examined in person when:

i. Patient G was requesting two similar drugs for ongoing chronic back pain; To be determined

ii. new or worsening disc problems needed to be excluded; To be determined

b. prescribed more than one codeine-based opiate to Patient G when there was no clinical reason to do so. To be determined

5. On 9 March 2020 you issued a prescription for zapain and codeine to Patient H for the concerns set out in Schedule 5, which was inappropriate as you prescribed more than one codeine-based opiate to Patient H when there was no clinical reason to do so. To be determined

6. On 14 March 2020 you issued a prescription for codeine and dihydrocodeine to Patient I for the concerns set out in Schedule 6, which was inappropriate as you:

a. failed to:

i. advise Patient I to consult with their own GP for an examination in person; To be determined

ii. recognise red flag(s), in that:

1. Patient I had been prescribed multiple potent opiates in the past, which could have suggested opiate tolerance or addiction; To be determined

2. Patient I's own GP had refused to prescribe the drug(s); To be determined

b. prescribed more than one codeine-based opiate to Patient I when there was no clinical reason to do so. To be determined

7. On 15 March 2020 you issued a prescription for dihydrocodeine to Patient J for the concerns set out in Schedule 7, which was inappropriate as you failed to:

a. ensure that Patient J was examined in person given that they had sustained an acute injury; To be determined

b. consider that Patient J may need an onward referral for the injury. To be determined

8. On 16 March 2020 you issued a prescription for dihydrocodeine, codeine, naproxen and co-dydramol to Patient K for the concerns set out in Schedule 8, which was inappropriate as you:

a. failed to recognise the red flag of Patient K requesting multiple opiate prescriptions; To be determined

b. prescribed more than one potent opiate to Patient K when there was no clinical reason to do so. To be determined

9. On 27 March 2020 you issued a prescription for codeine and amitriptyline to Patient L for the concerns set out in Schedule 9, which was inappropriate as amitriptyline was not clinically indicated for a bony fracture given the history provided by Patient L in their online questionnaire. To be determined

10. On 31 March 2020 you issued a prescription for remedeine forte and co-codamol to Patient M for the concerns set out in Schedule 10, which was inappropriate as you:

a. failed to ensure that Patient M was examined in person to exclude more serious pathology prior to prescribing the medication; To be determined

b. prescribed more than one potent opiate to Patient M when there was no clinical reason to do so. To be determined

11. On 1 April 2020 and 10 April 2020, you issued a prescription to Patient N for codeine which was inappropriate as you had prescribed duplicate opiate medication within a ten-day period. To be determined

12. On 2 April 2020 you issued a prescription for codeine and dihydrocodeine to Patient O for the concerns set out in Schedule 11, which was inappropriate as you prescribed more than one codeine-based opiate to Patient O when there was no clinical reason to do so; To be determined

13. On 3 April 2020 you issued a prescription for codeine and dihydrocodeine to Patient P for the concerns set out in Schedule 12, which was inappropriate as you prescribed more than one codeine-based opiate to Patient P when there was no clinical reason to do so. To be determined

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

The Admitted Facts

9. At the outset of these proceedings, through his counsel, Mr Gillespie, Dr Shonde made admissions to paragraph 1 of the Allegation as amended, as set out above, in accordance with Rule 17(2)(d) of the Rules. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced paragraph 1 of the Allegation as admitted and found proved.

The Facts to be Determined

10. In light of Dr Shonde's response to the Allegation made against him the Tribunal was required to determine the remainder of the Allegation.

Witness Evidence

11. The Tribunal received evidence on behalf of the GMC from the following witnesses: Ms A, inspector employed by the GPhC, via video link.

12. Dr Shonde provided his own witness statement, dated 9 July 2025 and produced a supplemental witness statement during the course of the hearing, dated 24 July 2025. He also gave oral evidence to the Tribunal.

Expert Witness Evidence

13. The Tribunal also received evidence from Dr B, a GP of many years standing, via video link. Dr B had also provided an expert report dated 30 March 2023 and two supplemental expert reports, dated January 2024 and April 2025.

Documentary Evidence

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

- An email from Ms A to Dr C, Superintendent Pharmacist at LBM, dated 20 November 2019.
  In this Ms A raised recent issues with online prescribing pharmacies and attached the *GpHC Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet [April 2019]*.
- A copy of the Enforcement Action summary, dated 24 April 2020. As a result of the concerns conditions were imposed on LBM.
- Ms A's Inspection Report.
- The Script Book/private prescription register relating to the Patient A – P.
- Email correspondence between Mr D, Director, LBM to Dr Shonde, dated 12 December 2019. In this Dr Shonde had agreed to handle the clinical management of patients whilst they obtained CQC registration.
- Patient Questionnaires and prescription for Patients A – P.
- Dr Shonde's Curriculum Vitae.
- Various WhatsApp screenshots of messages Dr Shonde sent in relation to prescriptions.
- Dr Shonde's Rule 7 Response.

The Tribunal's Approach

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

16. The LQC advised that the Tribunal is entitled to take into account Dr Shonde's good character when assessing his credibility and the likelihood of him having done what is alleged.

Whilst good character is not a defence to the allegation, it is a factor to be taken into account when considering all the evidence.

17. The LQC advised that the Tribunal is entitled to draw proper inferences and to come to common sense conclusions based upon the evidence which it accepted as reliable; but it must not speculate. The Tribunal should only draw an inference if it could safely exclude other possibilities [*Soni v GMC [2015] EWAC 0364 Admin*].

18. The LQC advised that the Tribunal must consider the expert evidence and see it in its proper perspective, as part of the evidence as whole. The Tribunal should consider the experts' evidence and attach such weight to it as considered appropriate in being able to make a determination on the outstanding denied factual allegations. The Tribunal should bear in mind that if, having given the matter careful consideration, they determine not to accept the evidence of an expert, they do not have to accept it. Indeed, the Tribunal do not have to accept even any unchallenged areas of evidence of an expert, but it is for them to decide whose evidence, and whose opinions to accept, if any. However, if the Tribunal do not accept the expert evidence, then they should give reasons within the record of the decision.

The Tribunal's Analysis of the Evidence and Findings

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

20. The Tribunal bore in mind the admissions made by Dr Shonde in relation to paragraphs 1a-d of the Allegation, namely that between February 2020 and April 2020, he issued in excess of 1,000 prescriptions and on one or more occasion, including for one or more prescriptions, failed to obtain an adequate clinical history of the patient prior to prescribing the medication by either physically seeing/and or examining the patient himself, discussing the patient's case with their GP, accessing the patient's medical records; or reviewing the patient's medical records to ascertain whether the patient required a physical examination.

21. The Tribunal bore in mind Dr Shonde's acknowledgement, as outlined in his witness statement, that in his role at LBM he fell short of several key expectations as set out in the Good Medical Practice (2013 version)('GMP'), particularly in respect of safe prescribing and outlined specifically:

'a. Paragraph 12 of 2013 GMP states that doctors must keep up to date with, and follow, the law, guidance and other regulations relevant to their work. I now recognise that I should have been more alert to the limitations of remote prescribing in light of this guidance.

b. Paragraph 16(a) of 2013 GMP requires that doctors prescribe drugs only when they have adequate knowledge of the patient's health. I acknowledge that the use of online questionnaires, while intended to gather relevant information, did not reliably provide the depth of understanding required. While I recognised the limitations of the questionnaires and therefore routinely sought additional information from patients before deciding whether to prescribe, I now appreciate that this additional step, though well intentioned, still did not bring the process in line with the standards expected. However, it is important to note that in case where the information remained insufficient or raised concerns, I did not proceed with issuing a prescription.

c. Paragraphs 51 and 61 of the 2013 Prescribing Guideline then in force emphasise the need for suitable arrangements for monitoring, follow-up, and adequate assessment when prescribing remotely. I accept that the system in place at LBM fell short of these standards in respect of accessing medical records and ensuring sufficient verification before prescribing.

d. I accept that my involvement in the prescribing process at LBM did not meet the requirements of paragraph 30 of the 2013 Prescribing Guideline, which emphasises the importance of sharing relevant information with colleagues involved in the patient's care at the appropriate time. Whilst it was part of the LBM model to notify patients' GPs following the issuances of a prescription, and such notifications were in fact routinely made, I acknowledge that this post-prescription contact did not meet the standard expected for responsible prescribing. I included at Exhibit AS2 a copy of the invoices issued in connection with the preparation of GP notification letters. For clarity, these invoices did not relate to any payment made to me personally as I was not renumerated by LBM in any form. The invoices solely reflect the administrative time spent by my secretary in typing and preparing the letters. The purpose of including these is to demonstrate that steps were taken to facilitate communications with GPs, albeit after the initial prescription had been issued. Nonetheless, I now recognise that pre-prescription communication was a necessary safeguard, particularly when prescribing controlled drugs, and that its absence contributed to a prescribing process that fell short of the standards required.'

Paragraphs 4b, 5, 6b, 8b, 10b, 12 and 13

22. The Tribunal first considered the double prescribing allegations particularised at paragraphs 4b, 5, 6b, 8b, 10b, 12 and 13 of the Allegation, relating to Patients G, H, I, K, M, O and P. These had been the subject of Mr Gillespie's Rule 17(2)g application which the Tribunal refused for its reasons at outlined in Annex A.

23. In his oral evidence Dr Shonde stated that on first seeing two opioids prepopulated on the prescriptions, he flagged it to the IT department and introduced a 'workaround' that included only entering instructions for use for the opioid he wanted to prescribe. He told the Tribunal that this was understood by those dispensing the medication as instructions only to issue that drug. Mr Gillespie for Dr Shonde took the Tribunal through the script book ('the register') of what was actually dispensed, which reflected these instructions and showed that only the opioid with instructions next to it had been dispensed.

24. In Ms A's evidence in relation to Patient G, she stated that looking at the prescription form it looked like codeine and zapain had been prescribed. She accepted however that only one appeared to have been sent and stated that there must have been 'some intervention' which stopped both opioids being dispensed. Dr Shonde stated in evidence that whilst there was not a written protocol, there was a verbal agreement with the superintendent pharmacist that they should only issue the drug for which specific instructions were added. The Tribunal noted that the evidence consistently showed that only the drugs for which instructions had been added were actually dispensed, and considered that in the absence of any other explanation, it was more likely than not that it was Dr Shonde's system or 'work around' that was responsible.

25. The Tribunal was also mindful that where Dr Shonde intended to prescribe two drugs and wrote instructions for both of them, these were issued according to the register. It was therefore satisfied that although two opioids had been added to the draft prescription generated, Dr Shonde only prescribed one.

26. Accordingly, the Tribunal found paragraphs 4b, 5, 6b, 8b, 12 and 13 of the Allegation not proved.

Paragraphs 2a, 4a, 7a and 10a

27. The Tribunal next considered the paragraphs of the Allegation where it is alleged that Dr Shonde failed to ensure that the patient was examined in person; paragraphs 2a, 4a, 7a and 10a, relating to Patient's D, G, J and M.

28. Mr Gillespie submitted that Dr Shonde had no capacity or ability to 'ensure' that a patient was examined either by himself or by their own GP. He stated that he could at most advise the patient that they should be examined but that it was entirely the patient's decision to accept the advice or not. Mr Barton for the GMC stated that Dr Shonde did have the power to decide whether or not to prescribe, and that what was alleged was that the prescription was inappropriate because of the lack of physical examination. The GMC's case was that in the absence of a physical examination, Dr Shonde should not have prescribed.

29. The Tribunal considered that where Dr Shonde is alleged to have 'failed to ensure the patient was examined in person', the clear meaning was that in the absence of such an examination, however it was achieved, he should not have proceeded to prescribe the drugs.

Paragraph 2a

30. The Tribunal considered whether on 21 February 2020 Dr Shonde issued a prescription for dihydrocodeine to Patient D for 'Trapped and bulging discs in lumbar region' and 'trapped nerve right sacroiliac joint' and failed to ensure that Patient D was examined in person given that they did not appear to have a current GP and therefore; i) needed an updated assessment of their pain; and ii) may have needed a referral to orthopaedics or physiotherapy.

31. The Tribunal had regard to Patient D's questionnaire, dated 21 February 2020. Patient D provided details of a GP practice in South-West London and they also detailed that they had *'just moved to Sheffield and not registered with a GP yet.'* The Tribunal also noted that Dr B said in her evidence that Patient D might have been removed from the London GP practice register if he had told them that he had moved.

32. The Tribunal considered that Patient D may have been de-registered from the GP practice in South London, given they had moved to Sheffield, and on their own admission had not obtained a new GP. The Tribunal concluded that on the information provided in the questionnaire it was logical to infer that Patient D did not 'appear' to have a current GP.

33. In his evidence Dr Shonde said that he was under the impression that Patient D was under GP supervision and that Patient D's care would be picked up at a pain clinic. The Tribunal considered this to be a big assumption which was not supported by the evidence.

34. The Tribunal noted that according to the Questionnaire, Patient D's diagnosis of bulging discs and trapped nerves was made in 2017. The Tribunal considered that this was an ongoing problem and it was mindful that according to the guidance opioids are not indicated for chronic pain, as highlighted by Dr B.

35. In relation to opioid prescribing for chronic pain, Dr B stated in her report that:

> *'Opioids are very good analgesics for acute pain and pain at the end of life but there is little evidence that they are helpful for long-term pain. Despite this, they are widely prescribed for this reason – opioid prescribing more than doubled in the period 1998 to 2018. This has been referred to as an opioid epidemic in the UK, similar but not at the same scale as the opioid crisis in the USA.*
>
> *The harms of this prescribing are now better understood, and government is regulating further. The Medicines and Healthcare products Regulatory Agency will now ensure that packs of opioid medication carry clear warnings about the risks of addiction and dependence. Doctors that specialise in pain have observed that over time the principles used in prescribing for acute pain and pain at the end of life have been applied to the field of chronic pain, despite a lack of evidence of effectiveness and the potential for harm. Guidance from NICE is clear that opioids are not indicated for chronic pain, and guidance from the Royal College of Anaesthetists (the professional body for doctors that specialise in pain) has been clear about the harm that can be caused..'*

36. In Dr Shonde's evidence he stated that he has known instances where opioids have been legitimately prescribed in circumstances such as those in this case. Whilst there may be instances where opioids could be legitimately prescribed, Dr B was clear that where there is no detailed pain assessment, such a prescription would be rare and would only be appropriate where there was strong reasons to do so. The Tribunal could see no strong reasons for doing so in this case.

37. In her report, Dr B stated that:

'In my opinion, prescribing Dihydrocodeine, Codeine, Co-dydramol, Remedeine Forte, Pregabalin, Amitriptyline and Co-codamol 30/500mg without the necessary clinical information was seriously below the standard expected of a prescribing doctor. In my opinion, prescribing Dihydrocodeine and other opiates online is unsafe, and that Dr Shonde prescribed it, given limited clinical information, is seriously below the standard expected of a reasonably competent prescribing doctor. In my opinion, Dr Shonde failed to take cognisance of the GMC remote prescribing sections of the Good Practice in Prescribing and Managing Medicines and Devices. In my opinion, Dr Shonde failed to take cognisance of the GMC remote prescribing sections of the Good Practice in Prescribing and Managing Medicines and Devices 2013 particularly sections 3, 9, 11, 14, 15, 21, 24, 32, 33, 37, 39, 41, 51, 52, 53, 55-61, 64 and 66 and that this could have led to patient harm. I also refer to NICE NG46 section 1.5 and GMC Good Medical Practice sections 15, 16 and 21.'

38. The Tribunal considered that whilst it was not in Dr Shonde's power to arrange a referral, it was within his power to decide that opioids were not appropriate in the absence of such and to advise that Patient D be examined and assessed. Dr Shonde did not have to issue the prescription.

39. The Tribunal determined that Dr Shonde's decision to prescribe dihydrocodeine was inappropriate for the reasons set out in paragraphs 2ai-ii of the Allegation.

40. Accordingly, the Tribunal found paragraph 2ai-ii proved.

Paragraph 4a

41. The Tribunal considered whether on 6 March 2020, Dr Shonde issued a prescription for codeine and zapain to Patient G for lower back pain, which was inappropriate as he failed to ensure that Patient G was examined in person when (i) Patient G was requesting two similar drugs for ongoing chronic back pain; and (ii) new or worsening disc problems needed to be excluded.

42. The Tribunal had already determined that Dr Shonde did not actually prescribe two opioids, and therefore considered Paragraphs 4 ai and ii in relation to the prescription of zapain only.

42. Dr Shonde admitted that with Patient G, as with other patients, he failed to obtain an adequate clinical history. He also accepted that he was aware of the guidance for prescribing

controlled drugs which advises caution in relation to the prescription of codeine and that a request for two controlled opioids was a clear red flag. However, he did not provide evidence of how he reacted to this red flag in this case and only relayed what his usual practice was.

43. In Dr Shonde's witness statement he stated that:

'Where submitted questionnaires were incomplete or raised clinical uncertainties, I would direct the administrative team to obtain further clarification before a prescription could be considered. I provided lists of specific questions to be put to the patient and required supporting documentation where appropriate. While I did request that GP contact be made in certain scenarios, I acknowledge that I should have exercised greater oversight to ensure that this was actioned appropriate, particularly prior to the first prescription being issued. Where I thought direct GP contact was required before issuing prescriptions, I asked the administration to contact the patients GP…'

44. In his supplemental statement produced during the hearing he said that *'Requests for more than one opioid would, in and of themselves, constitute a red flag and prompt me to take additional steps.'* He stated that in such situations he would ask the administrative team to obtain supporting documentation from the patient to verify the clinical indication and safeguard the appropriateness of any prescription. He stated that this would include:

'(i) a green prescription log, usually issued by the patient's GP, which confirmed their current prescribed medication. I would only accept logs issued within the preceding 12 months to ensure accuracy; or

(ii) a clinic or secondary care letter, typically from a pain clinic, confirming the relevant diagnosis and treatment plan, including details of any prescribed opioids. These were also required to be no more than 12 months old…

Where a patient could not provide such documentation, or where further uncertainty remained, I would direct the administrative team to contact the patient's GP for confirmation. Prescriptions would remain on hold until appropriate clarification had been received. Where no response was received, the prescription request would be declined.

I must reiterate that it was my standard practice to prescribe only one opioid per patient per occasion, regardless or the content of the request. This principle formed a core part of my approach to safe prescribing in an online setting..'

45. The Tribunal bore in mind Dr Shonde's good character and record of service when considering his testimony. He has admitted Paragraph 1 of the Allegation, but the Tribunal do not find that this of itself impacts his credibility, though it may show that to some extent, in some cases, he was content to prescribe without first obtaining an adequate clinical history. Dr Shonde told the Tribunal that whenever a patient requested two or more opioids he would first want to see either the green prescription log from the patient's general practitioner or a clinic letter setting out pain management to date, such as that which he provided exhibited to his supplemental witness statement. He said this would be requested via administrative staff at his request. He could provide no examples of such requests, saying they were usually verbal.

46. Dr Shonde accepted he has no recollection of specific cases. He did not seek to tell the Tribunal that this specifically occurred in the cases subject to the Allegation, but stated that it was his practise to do so in all cases where duplicate opioids were requested. The Tribunal have heard various examples of failed work practices within LBM, and bore in mind this was a new company without set and established working procedures. The Tribunal therefore looked at each instance to seek any evidence as to whether such additional material was or may have been available to Dr Shonde in each specific case.

47. The Tribunal therefore had regard to the questionnaire and prescription for Patient G. Both were dated 6 March 2020. The script book/register showed that the prescription was dispensed the following day on 7 March 2020. The Tribunal also noted that Dr Shonde had made a determination regarding the prescription within 5 hours of the request in Patient G's questionnaire. The questionnaire was completed at 12:07am on 6 March 2020, and at 05:38 Dr Shonde had sent a WhatsApp stating 'Only Zapain prescribed'.

48. The Tribunal found it difficult to accept that there could have been correspondence between LBM and Patient G or with Patient G's doctor which resulted in the provision to Dr Shonde of the specific extra evidence he sought in such a timescale. The Tribunal therefore concluded that on the balance of probabilities in relation to this patient Dr Shonde would not have had additional medical evidence such as he told the Tribunal he would require.

49. In Dr B's report, she commented in regard to the history taken that:

> *'Limited history given diagnosed with disc issue in 2017 resulting in back pain. Made worse by sneezing or sudden movement, made better with swimming or heat. No musculoskeletal or neurological examination. (Examination required of neck, upper back and shoulder to ascertain presence or absence of loss of power, loss of sensation, muscle*

atrophy, range of movement and assessment of gait). Also this appears to be a chronic ongoing problem.'

50. In her opinion as to whether the drug prescribed by Dr Shonde was clinically indicated, she stated:

'No, insufficient history, chronic problems and may have underlying renal disease affecting ability to tolerate opiates. No, opiates not indicated for bony or chronic pain. May be indicated for short term use in acute pain, once assessed. In my opinion, the medication was inappropriate as the history given is insufficient to allow for a prescription of a potent opiate and opiates are not indicated or effective in chronic pain.

I refer to: Opiates for Chronic Pain NHS England
Opioid prescribing for chronic pain

Opioids are very good analgesics for acute pain and pain at the end of life but there is little evidence that they are helpful for long-term pain…'

51. Dr B had also stated that it was also a red flag that the patient requested two similar medications that they were prepared to pay for, yet they were living in Scotland where they would be free. In Dr Shonde's evidence he stated that his geography was not the best and that he did not appreciate the location of patients when prescribing, as such he had not appreciated the patient's location as a red flag. The Tribunal did not consider this a significant factor, as every patient was in effect paying a lot more for their prescription than they would via the NHS, such was the nature of the service provided by LBM.

52. The Tribunal considered that opioid seeking behaviour from patients may not have been on Dr Shonde's radar, however, it considered this to be incongruous with the evidence that he provides mentoring to prisoners, including with drug issues, and as such he ought to have been aware of the issues of opioid addiction.

53. The Tribunal determined that on the balance of probabilities Dr Shonde had no medical history available to him beyond that contained within the questionnaire and that for the reasons set out by Dr B the prescription was therefore inappropriate. Accordingly, the Tribunal found paragraph 4ai-ii proved.

Paragraph 7

54. The Tribunal considered whether on 15 March 2020, Dr Shonde issued a prescription for dihydrocodeine to Patient J for a torn rotator cuff and whether this was inappropriate as he failed to ensure that Patient J was examined in person given that they had sustained an acute injury, and failed to consider that Patient J may need an onward referral.

55. Dr Shonde stated that as the patient had recently been to hospital where they would have been examined a prescription of a short course of analgesia was reasonable.

56. In Dr B's report, she stated Dr Shonde did not know when Patient J was last seen or examined or last had the prescription. She stated:

> *'Limited history given: Right shoulder injury within last 2 weeks. Seen at hospital but may not have seen own GP as could have been given supply of medication by the hospital. May be getting prescribed Dihydrocodeine by own GP. Dr Shonde would need to clarify if Patient J has a current prescription. No examination of acute injury – deformity, swelling, evidence bruising, site of pain, radiation, range of movement… Dihydrocodeine could be indicated for acute shoulder injury, but Dr Shonde would need access to medical notes to confirm diagnosis and reconcile any medication prescribed..'*

57. The Tribunal considered that although Dr Shonde was not able to force Patient J be examined in person or go for an onward referral, it was within his power to decline to prescribe dihydrocodeine in the absence of such.

58. The Tribunal determined that Dr Shonde did not give sufficient regard to the need for caution in the prescription of dihydrocodeine, as required by the published Guidance, and that the prescription was inappropriate for the reasons set out in the report of Dr B. Accordingly, the Tribunal found paragraphs 7a and 7b proved.

Paragraph 10a

59. The Tribunal considered whether on 31 March 2020, Dr Shonde issued a prescription for co-codamol to Patient M for back pain, and whether this was inappropriate as he failed to ensure that Patient M was examined in person to exclude more serious pathology prior to prescribing the medication.

60. Dr Shonde accepted in his admission to Paragraph 1 that he did not have an adequate clinical history. As considered above, he stated that where there was a request for two opiates, as here, he would have sought further information. The Tribunal considered that it

was highly unlikely that Dr Shonde received further information in this case because the prescription was issued on the same date that Patient M's questionnaire was received, on 31 March 2020. Again, there is no independent evidence such material was received and considered.

61. In her report, Dr B stated that an examination was required of Patient M's *'back and lower legs to ascertain presence or absence of loss of power, loss of sensation, muscle atrophy, assessment of gait')*. She stated that it also appeared to be a chronic ongoing problem and that opiates were not indicated for bony or chronic pian. In answer whether an examination was indicated, she stated:

> *'Yes, given pain score of 3 and the fact that Dr Shonde does not know when she was last seen or examined or last had the prescription. Yes, requesting 2 potent opiates for chronic back pain. Need to exclude more serious pathology.'*

62. The Tribunal considered that Dr B was clear in her evidence that an examination was required to exclude more serious pathology prior to prescribing the medication. Again, whilst Dr Shonde could not ensure that Patient M was examined, he did not have to issue the prescription. As the Tribunal has determined above that on the balance of probabilities further medical evidence of the patient's history was not available to Dr Shonde, for the reasons set out by Dr B the Tribunal are satisfied to the same standard that the prescription was inappropriate.

63. Accordingly, the Tribunal found paragraph 10a proved.

Paragraph 6

64. The Tribunal considered whether on 14 March 2020, Dr Shonde issued a prescription for codeine to Patient I for 'left-sided chest wall and back pain' and whether this was inappropriate as he: (a) failed to; (i) advise Patient I to consult with their own GP for an examination in person; (ii) recognise red flag(s), in that 1. Patient I had been prescribed multiple potent opiates in the past, which could have suggested opiate tolerance or addiction; 2 Patient I's own GP had refused to prescribe the drug(s); and (b) prescribed more than one codeine-based opiate to Patient I when there was no clinical reason to do so.

65. This was a case where the patient had also requested dihydrocodeine, although Dr Shonde only prescribed codeine. Dr B stated that there were also other very strong red flags present in Patient I's case. These included that Patient I's GP was not willing to prescribe, that they might be using another online prescriber and were already taking pethidine, 200mg a

day – which is a significant dose. In reference to Patient I's questionnaire and the answer to the questions 'what medications have you tried that relieve your pain?' she commented that '*almost every drug of abuse in the book*' was there, noting tramadol, fentanyl, amitriptyline, gabapentin and pethidine. She stated that all these were red flags and to her the patient is drug seeking.

66. The Tribunal noted that the date of the questionnaire was 14 March 2020 and the prescription made by Dr Shonde was also the 14 March 2020 and it was issued on 16 March 2020. The Tribunal considered that these dates show that on the balance of probabilities Dr Shonde did not receive additional information to that in the questionnaire before making a prescription.

67. In Dr Shonde's statement he stated:

> *'Patient I presented with a clear, long-standing diagnosis of nerve damage resulting in chronic pain, which had been previously diagnosed and managed by a pain consultant in January 2017. This diagnosis was self-reported in the questionnaire, and the patient's account included a detailed history of their pain, location (back radiating to the chest wall), and previously trialled medications. These included gabapentin, amitriptyline, fentanyl patches, tramadol, co-codamol, and pethidine, demonstrating a well-documented treatment journey under specialist care.*
>
> *Importantly, the patient did not state anywhere in their response that their GP had refused to prescribe the requested medication. The reference in the questionnaire to the GP not asking the NHS to fund medication appears to relate to cost or logistical issues, not a clinical refusal to prescribe. There is no reference to the GP declining to prescribe due to safety, tolerance, or addiction concerns. The questionnaire instead focussed on the patient seeking a more affordable source of their medication due to cost, NHS shortages, and fear of COVID exposure, which were common challenges in early 2020.'*

68. The Tribunal considered that Dr Shonde put a lot of reliance on the statement in the questionnaire that the GP declined to prescribe on the basis of cost. The Tribunal considered that codeine and dihydrocodeine were unlikely to be declined on the basis of cost, as they were not new drugs and are not prohibitively expensive. The Tribunal noted that the script register shows the cost of these drugs to be under £10.

69. The Tribunal also considered that a doctor of Dr Shonde's experience, including his work with prisoners as mentioned in paragraph 52, should have better recognised the better potential indicators of 'drug seeking.'

70. The Tribunal determined that the prescription issued by Dr Shonde was inappropriate on the basis of the information available to him for the reasons set out by the expert Dr B and that instead Patient I should and could have been advised to consult their GP.

71. Accordingly, the Tribunal found paragraph 6a proved.

Paragraph 3

72. The Tribunal considered whether on 26 February 2020 Dr Shonde issued a prescription for co-codamol to Patient F for fibromyalgia and migraines and whether this was inappropriate as he failed to review Patient F's medical records to decide whether they required a physical examination to exclude other pathology.

73. In Dr B's report she stated that there was:
'.. insufficient history, chronic problems and may have underlying renal disease affecting ability to tolerate opiates. No, opiates not indicated for bony or chronic pain. May be indicated for short term use in acute pain, once assessed. In my opinion, the medication was inappropriate as the history given is insufficient to allow for a prescription of a potent opiate and opiates are not indicated or effective in chronic pain.

I refer to: Opiates for Chronic Pain NHS England
Opioid prescribing for chronic pain *Opioids are very good analgesics for acute pain and pain at the end of life but there is little evidence that they are helpful for long-term pain…'*

74. Dr B also stated that:
'In my opinion, the history provided is insufficient to allow for a prescription of Co - Codamol to be safely prescribed. Patient F needs examination as having a flare up of her condition but her symptoms could be due to another pathology such as arthritis or injury. Needs examination.'

75. Dr B also stated in regard to the appropriateness of co-codamol, that Patient F *'may already be being prescribed it. High risk of duplicate prescription.'* In relation to red flags she

stated *'On long term opiates? Already receiving prescription from own GP? High risk of duplicate prescribing and risk of oversedation with Amitriptyline.'*

76. In Dr Shonde's statement he stated:

'This patient was prescribed co-codamol 30/500mg following a comprehensive questionnaire that provided a clear and credible history of fibromyalgia, diagnosed in 2009 by both a neurologist and GP. The questionnaire confirmed this was long-standing condition associated with intermittent flare-ups, which the patient was familiar with managing. The patient had been previously prescribed co-codamol 30/500mg for these episodes and stated that two tablets were effective in relieving the pain without side effects. The patient described her current presentation as a flare-up, triggered by cold weather and overexertion, with the pain distributed across joints and muscles, which are recognised classic features of fibromyalgia.

Important, this was not a new or evolving condition requiring physical examination. The patient confirmed that they had tried a range of medications (including paracetamol, ibuprofen, and lower-strength co-codamol) without sufficient relief, and reported no red flag symptoms such as unexpected weight loss, changes in bowel habit, abnormal bleeding, or systemic illness. Their pain score at the time of filing the questionnaire was recorded as moderate, and their responses indicated functional awareness and safety in using medication previously prescribed for the same symptoms.

The patient was in the process of seeking a new GP due to appointment availability and had no history of substances misuse or contraindicating comorbidities/ they supplied their height and weight, and the responses throughout were consistent with someone familiar with the episodic nature of their conditions. Given the known diagnosis, past use of the same medication, absence of new or red flag symptoms, and lack of any clinical concern suggesting deterioration, I did not consider it clinically necessary to obtain medical records or insist upon physical examination prior to issuing a short course of a familiar analgesic…'

77. Dr B stated that prescribing Patient F co-codamol could have been safe and reasonable, but this needed to be corroborated by review of the medical records. Bearing in mind the guidance on remote prescribing of opiates and Dr B's evidence, the Tribunal considered that it was inappropriate to prescribe Patient F co-codamol without review of Patient F's medical records to decide whether they required a physical examination to

exclude other pathology. This was especially important given the high risk of duplicate prescription identified by Dr B as Patient F was already using co-codamol.

78. The Tribunal therefore found paragraph 3 proved.

Paragraph 8a

79. The Tribunal considered whether on 16 March 2020 Dr Shonde issued a prescription for dihydrocodeine and naproxen to Patient K for back pain and whether this was inappropriate as he failed to recognise the red flag of Patient K requesting multiple opiate prescriptions. This is a case where multiple opioids were requested but the Tribunal have determined that only one was actually prescribed by Dr Shonde.

80. Dr B stated in relation to red flags, that Patient K may already be getting medications from their GP and could be at risk of duplicate prescribing, and that it was a red flag requesting multiple opioids.

81. Dr Shonde accepted that the request for multiple opioids was a red flag and that accordingly he would have requested supporting evidence of medical history. However, the Tribunal noted that Patient K's questionnaire was received on 16 March 2020 and the prescription was issued the same day. The Tribunal considered that on the balance of probabilities Dr Shonde would not have received any supporting material and that therefore his prescription was based solely on the information contained in the questionnaire.

82. In the absence of evidence that Dr Shonde took any action to ensure he received and reviewed further information prior to issuing the prescription the Tribunal was not satisfied that Dr Shonde truly recognised the significance of the request for multiple opioids to be a red flag. The Tribunal considered that recognising a red flag involves both identifying and addressing the concerns it raises.

83. The Tribunal, therefore, found paragraph 8a proved.

Paragraph 9

84. The Tribunal considered whether on 27 March 2020, Dr Shonde issued a prescription for codeine and amitriptyline to Patient L for a fractured fibula, and whether this was inappropriate as amitriptyline was not clinically indicated for a bony fracture given the history provided by Patient L in their online questionnaire.

85. In her report, Dr B stated that there was insufficient history regarding Patient L's injury to allow for safe prescribing of codeine and amitriptyline. She stated that codeine could be indicated for post fracture pain but that Dr Shonde would need access to the patient's medical records and the patient would require a pain assessment. She that there was:

> *'No clinical indication for 10mg Amitriptyline or evidence ever prescribed by GP. Amitriptyline at the 10mg dose is usually prescribed for neuropathic pain or as night sedation. It is an antidepressant at higher doses. Patient L would not, in my opinion, have been prescribed this by the hospital and was unlikely to be prescribed by the GP for a bony fracture. …'*

86. In Dr Shonde's evidence he told the Tribunal that it was not unusual to prescribe amitriptyline as an adjunct to codeine and the Tribunal accepted that amitriptyline could be used to enhance analgesia and help reduce opioid dosage. However, it noted a lower dose of codeine was not given alongside the amitriptyline.

87. The Tribunal concluded that although it accepted that amitriptyline may in certain cases be appropriate for bony injury alongside other analgesia, there was insufficient information available to Dr Shonde to show that its use was clinically indicated in this particular case. It concluded that it was therefore inappropriate to prescribe it on the evidence available to him.

88. Accordingly, the Tribunal found paragraph 9 proved.

Paragraph 11

89. The Tribunal considered whether on 1 April 2020 and 10 April 2020, Dr Shonde issued a prescription to Patient N for codeine which was inappropriate as he had prescribed duplicate opiate medication within a ten-day period.

90. The Tribunal noted the date of the first prescription for Patient N was dated 31 March 2020, not 1 April 2020. The date of the second prescription according to the 'Paper Date' on the register, which Ms A stated was the date of prescription, was 10 April 2020. This was eleven days after the first prescription.

91. The Tribunal bore in mind the concerns Dr B had about the prescriptions to Patient N and their appropriateness, and that she stated that even if there was a 12 day period between them it would not have been appropriate. However, given the allegation clearly

specifies a ten-day period, and that there was actually eleven days between the first and second prescription, the Tribunal found this allegation not proved.

The Tribunal's Overall Determination on the Facts

92. The Tribunal has determined the facts as follows:

1. Between February 2020 and April 2020, whilst working for Letter Box Meds, you issued in excess of 1,000 prescriptions, and on one or more occasion, including for one or more of the prescriptions set out in Schedule 1, you failed to obtain an adequate clinical history of the patient prior to prescribing the medication by either:
    a. physically seeing and/or examining the patient yourself; **Admitted and found proved**
    b. discussing the patient's case with their GP; **Admitted and found proved**
    c. accessing the patient's medical records; or **Admitted and found proved**
    d. reviewing the patient's medical records to ascertain whether the patient required a physical examination. **Admitted and found proved**

2. On 21 February 2020 you issued a prescription for dihydrocodeine to Patient D for the concerns set out in Schedule 2, which was inappropriate as you:
    a. failed to ensure that Patient D was examined in person given that they did not appear to have a current GP and therefore:
        i. needed an updated assessment of their pain; **Determined and found proved**
        ii. may have needed a referral to orthopaedics or physiotherapy. **Determined and found proved**

3. On 26 February 2020 you issued a prescription for co-codamol to Patient F for the concerns set out in Schedule 3, which was inappropriate as you failed to review Patient F's medical records to decide whether they required a physical examination to exclude other pathology. **Determined and found proved**

4. On 6 March 2020 you issued a prescription for codeine and zapain to Patient G for the concerns set out in Schedule 4, which was inappropriate as you:

    a. failed to ensure that Patient G was examined in person when:

i. Patient G was requesting two similar drugs for ongoing chronic back pain; **Determined and found proved**

ii. new or worsening disc problems needed to be excluded; **Determined and found proved**

b. prescribed more than one codeine-based opiate to Patient G when there was no clinical reason to do so. **Not proved**

5. On 9 March 2020 you issued a prescription for zapain and codeine to Patient H for the concerns set out in Schedule 5, which was inappropriate as you prescribed more than one codeine-based opiate to Patient H when there was no clinical reason to do so. **Not proved**

6. On 14 March 2020 you issued a prescription for codeine and dihydrocodeine to Patient I for the concerns set out in Schedule 6, which was inappropriate as you:

a. failed to:

i. advise Patient I to consult with their own GP for an examination in person; '**Determined and found proved**

ii. recognise red flag(s), in that:

1. Patient I had been prescribed multiple potent opiates in the past, which could have suggested opiate tolerance or addiction; **Determined and found proved**

2. Patient I's own GP had refused to prescribe the drug(s); **Determined and found proved**

b. prescribed more than one codeine-based opiate to Patient I when there was no clinical reason to do so. **Not proved**

7. On 15 March 2020 you issued a prescription for dihydrocodeine to Patient J for the concerns set out in Schedule 7, which was inappropriate as you failed to:

a. ensure that Patient J was examined in person given that they had sustained an acute injury; **Determined and found proved**

b. consider that Patient J may need an onward referral for the injury. Determined and found proved

8. On 16 March 2020 you issued a prescription for dihydrocodeine, codeine, naproxen and co-dydramol to Patient K for the concerns set out in Schedule 8, which was inappropriate as you:
   a. failed to recognise the red flag of Patient K requesting multiple opiate prescriptions; Determined and found proved
   b. prescribed more than one potent opiate to Patient K when there was no clinical reason to do so. Not proved

9. On 27 March 2020 you issued a prescription for codeine and amitriptyline to Patient L for the concerns set out in Schedule 9, which was inappropriate as amitriptyline was not clinically indicated for a bony fracture given the history provided by Patient L in their online questionnaire. Determined and found proved

10. On 31 March 2020 you issued a prescription for remedeine forte and co-codamol to Patient M for the concerns set out in Schedule 10, which was inappropriate as you:
   a. failed to ensure that Patient M was examined in person to exclude more serious pathology prior to prescribing the medication; Determined and found proved
   b. prescribed more than one potent opiate to Patient M when there was no clinical reason to do so. Not proved

11. On 1 April 2020 and 10 April 2020, you issued a prescription to Patient N for codeine which was inappropriate as you had prescribed duplicate opiate medication within a ten-day period. Not proved

12. On 2 April 2020 you issued a prescription for codeine and dihydrocodeine to Patient O for the concerns set out in Schedule 11, which was inappropriate as you prescribed more than one codeine-based opiate to Patient O when there was no clinical reason to do so; Not proved

13. On 3 April 2020 you issued a prescription for codeine and dihydrocodeine to Patient P for the concerns set out in Schedule 12, which was inappropriate as you prescribed more than one codeine-based opiate to Patient P when there was no clinical reason to do so. Not proved

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

Determination on Impairment - 04/08/2025

93. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved as set out before, Dr Shonde's fitness to practise is impaired by reason of misconduct.

The Evidence

94. The Tribunal has taken into account all the evidence received during the facts stage of the hearing, both oral and documentary. In addition, the Tribunal received further oral evidence from Dr Shonde at this stage.

95. The Tribunal also received a further reflective statement from Dr Shonde and a Stage 2 bundle of documents which included, but was not limited to, a patient feedback report, Dr Shonde's reflections on guidance and learning undertaken, and various supportive testimonials.

Submissions

96. On behalf of the GMC, Mr Barton submitted that Dr Shonde's fitness to practise is impaired by reason of misconduct.

97. Mr Barton submitted that there was no burden of proof but the question of impairment was a matter for the Tribunal's judgement, and that it was a two stage test. It must first consider whether there has been misconduct and then whether as a result of that misconduct, Dr Shonde's fitness to practise was currently impaired.

98. Mr Barton submitted that in order to make a finding of misconduct, the Tribunal must determine whether the facts proved are a serious departure from the standards of conduct expected from a practitioner.

99. Mr Barton noted that it was conceded on behalf of Dr Shonde that his actions do amount to misconduct. Mr Barton reiterated that Dr Shonde had admitted paragraphs 1a-d of the Allegation and remotely prescribing opioids (and other drugs) on a large scale without

obtaining an adequate clinical history. The Tribunal had also found proved several specific instances of inappropriate prescribing.

100. Mr Barton submitted that the GMC expert, Dr B, considered Dr Shonde's course of conduct as falling seriously below the standards expected. Mr Barton submitted that the course of conduct also represented a clear risk to patient safety due to the inherent dangers with opioids. He submitted that Dr Shonde's course of conduct was not a short-lived single error of judgement but a sustained course of conduct over a five to six week period.

101. Mr Barton submitted that there was a risk to patient safety in each and every one of the 1000 patients to whom Dr Shonde had issued prescriptions without an adequate clinical history.

102. Mr Barton reminded the Tribunal of the departures from the relevant guidance and GMP as identified by Dr B. He also reminded the Tribunal that Dr Shonde admitted that he had breached parts of GMP 2013 and the GMC prescribing practice guidelines.

103. Mr Barton submitted that the matters admitted and found proved clearly constituted misconduct.

104. Mr Barton reminded the Tribunal of the test for impairment of fitness to practise as set out by Dame Janet Smith in the Fifth Shipman Report, as approved by the *High Court in CHRE v NMC and Paula Grant [2011] EWHC 297 Admin* (see paragraph 42 below). He submitted that Dr Shonde's actions presented a clear risk to patients, brought the profession into disrepute and had breached one or more of the fundamental tenets of the profession.

105. Mr Barton submitted that the Tribunal must consider the question of whether Dr Shonde's fitness to practise is presently impaired and that in order to form a view as to Dr Shonde's fitness to practise today, it will have to take into account the way in which he has acted or failed to act in the past.

106. Mr Barton submitted that the Tribunal must consider the overarching objective, which is to protect and promote the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession and to promote and maintain professional standards and conduct for members of the profession.

107. Mr Barton noted that it was accepted on behalf of Dr Shonde that his fitness to practise is currently impaired, but he did not accept that he presented a current risk to the safety and wellbeing of the public, as set out in the first limb of the overarching objective.

108. Mr Barton submitted that Dr Shonde's attitude to the events which gave rise to the allegations is something the Tribunal can take into account. He submitted that Dr Shonde's level of insight is also of relevance when considering whether he poses a current risk to patients. He referenced Dr Shonde's detailed reflective statement and the statements provided on the facts, and conceded that both documents contain passages of insight in which he does take responsibility for his actions.

109. Mr Barton submitted, however, that the Tribunal may take the view that Dr Shonde still seeks to lay blame at the door or Mr D and LBM, in spite of the fact that he helped draft the protocols that were in operation. Mr Barton submitted that when he was prescribing the opioids, Dr Shonde alone was responsible for ensuring he had an adequate clinical history to determine whether opioids were indicated and to identify any risks to patient safety.

110. Mr Barton submitted that in the Rule 7 Response Dr Shonde robustly denied any personal shortcomings or patient safety concerns; this was some four years or so after LBM had been shut down. He submitted that Dr Shonde's insight had been a relatively recent development. He also reminded the Tribunal that Dr Shonde produced in the course of the hearing a supplemental statement which set out a raft of additional checks and safeguards to apply whenever a patient requested more than one opioid. Mr Barton invited the Tribunal to consider in the light of its findings on this issue whether Dr Shonde has been totally candid or was still today seeking to minimise the true extent of his failings.

111. In summary, Mr Barton invited the Tribunal to conclude that Dr Shonde's fitness to practise is currently impaired. He submitted that whilst Dr Shonde may have begun the journey towards insight and remediation, he still has some distance to travel.

Submissions on behalf of Dr Shonde

112. On behalf of Dr Shonde, Mr Gillespie submitted that Dr Shonde accepts that his actions amounted to misconduct.

113. Mr Gillespie stated that it was accepted that Dr Shonde had acted in the past so as to bring the medical profession into disrepute and had breached fundamental tenets of the medical profession. Mr Gillespie submitted that for those reasons alone it was conceded that

the misconduct was serious and that a finding of impairment was inevitable, albeit that remained a matter for the Tribunal.

114. Mr Gillespie focussed on the element of the test set out by Dame Janet Smith and as approved in *Grant* as to whether Dr Shonde had *"in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm".* He submitted that it was accepted that Dr Shonde did put patients at risk of harm, but that there was no 'future risk'.

115. Mr Gillespie submitted that there was evidence to satisfy the Tribunal that Dr Shonde does not currently represent a risk to patients. He invited the Tribunal to consider Dr Shonde's various reflective statements and the accompanying documentation provided.

116. Mr Gillespie took the Tribunal through various parts of the patient feedback report and the testimonials provided in Dr Shonde's support. He submitted that these assist the Tribunal in terms of assessing the current risk as they show the Tribunal that it can be confident that Dr Shonde can and does practise safely and to the highest standards.

117. Mr Gillespie highlighted extracts from various testimonials speaking to Dr Shonde's clinical abilities, professionalism and integrity.

118. Mr Gillespie submitted that Dr Shonde fully accepts responsibility for his actions during his involvement with LBM. He submitted that Dr Shonde is aware that he has let himself down and has fallen away from the high standards expected.

119. Mr Gillespie submitted that in terms of assessing whether Dr Shonde currently represents a risk to patient safety, the Tribunal is entitled to take account that the misconduct arose outside of Dr Shonde's normal practice. He added that it was five years since the events, and whilst the conduct was sustained, it was all within a similar context outside his usual area of practice and limited to six weeks in decades of excellent service.

120. Mr Gillespie submitted that, put into its proper context, the risk to patients is now non-existent. He submitted that in Dr Shonde's current practice he does not prescribe opioids except in acute situations and in an entirely different context, where he has a full clinical history and in the presence of the patient. He submitted that the situation that arose at LBM simply does not arise in Dr Shonde's current practice and will not do so again.

121. Mr Gillespie submitted that Dr Shonde now has very firm views on the utility and efficacy of online pharmaceutical practice and that he would not be involved in remote prescribing in the future.

122. As regards insight, Mr Gillespie submitted that Dr Shonde acknowledged and takes full responsibility for his actions, both in his initial statement, in his evidence to the Tribunal and in his various reflective statements. He submitted that Dr Shonde was entitled to provide a degree of context, to explain the circumstances, and that is not the same thing as passing the blame. He submitted that Dr Shonde was not seeking to evade personal responsibility, because he always circled back to the point that it was his responsibility to check the guidelines and to ensure the protocols were in compliance with the guidelines. Mr Gillespie submitted that Dr Shonde has not resiled from that.

123. Mr Gillespie submitted that when Ms A was cross-examined it was clear that at the meeting which she had with LBM she had seen some document or protocol which satisfied her that she could authorise admission to the register. He submitted that Dr Shonde saw that as some support for the proposed working practices, but now accepts that he should not have relied on what was reported to him and should have dug deeper. He submitted that explaining this background to the Tribunal was not a sign of a lack of insight or trying to deflect the blame and said that Dr Shonde accepts that the 'buck stops with him'.

124. Mr Gillespie submitted that as a matter of principle Dr Shonde does not need to demonstrate that he gained the insight long ago and has long held it, but to satisfy the Tribunal that he has insight now.

125. Mr Gillespie submitted that the Tribunal should look at the quality of Dr Shonde's written and oral evidence and assess whether he has insight into what happened. He submitted that there are often cases where a doctor contests the allegation and can still demonstrate insight, as the courts have made clear.

126. In summary, Mr Gillespie submitted that impairment was accepted but not on the grounds of current or future risk to patient safety. He emphasised Dr Shonde's level of insight, that the events were a long time ago, that there has been no repetition and that Dr Shonde's current practice is a of wholly different nature, which means that this sort of problem is not going to recur.

The Relevant Legal Principles

127. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision of impairment is a matter for the Tribunal's judgement alone.

128. In approaching the decision, the Tribunal must be mindful of the two-stage process to be adopted: first whether the facts found proved amounted to misconduct which was serious; and secondly, whether the finding of serious misconduct should lead to a finding of impairment.

129. The Tribunal must determine whether Dr Shonde's fitness to practise is impaired today, taking into account his conduct at the time of the events and any relevant factors since then, such as whether the matters are remediable, have been remedied and any likelihood of repetition. It should also consider whether a finding of impairment is warranted taking into account the wider public interest.

130. The Tribunal was reminded of the guidance from the case of *Roylance v GMC [No 2] [2000] 1 AC 311* where it was advised that:

> '*misconduct is a word of general effect involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances.'*

131. In the case of *Nandi v GMC [2004] EWHC*, it was said that serious misconduct is that which would be regarded as 'deplorable' by fellow practitioners.

132. As per the case of *Cohen v GMC (2008) EWHC 581* in considering impairment the Tribunal should take into account the misconduct and then consider it in the light of all the other relevant factors. It will be highly relevant in determining if fitness to practise is impaired, to consider whether the misconduct is easily remediable, whether it has been remedied and whether it is likely to be repeated.

133. The Tribunal was also referred to the case of *Cheatle v GMC [2009] EWHC 645 (admin)* where it was stated that a doctor's misconduct at a particular time may be so 'egregious' that looking forward a panel is persuaded that the doctor is not fit to practise medicine without restriction or at all. Conversely, the doctor's misconduct may be such that seen within in the context of an otherwise unblemished record, a tribunal could conclude that their fitness to practise is not impaired despite the misconduct.

134. Whilst there is no statutory definition of impairment, the Tribunal was assisted by the guidance provided by Dame Janet Smith in the *Fifth Shipman Report*, as adopted by the High Court in *CHRE v NMC and Paula Grant [2011] EWHC 297 Admin.* The Tribunal noted that any of the following features are likely to be present when a doctor's fitness to practise is found to be impaired:

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

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

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

d. Has in the past acted dishonestly and/or is liable to act dishonestly in the future.'

135. Throughout its deliberations, the Tribunal must be mindful of its responsibility to uphold the overarching objective, as set out in the Medical Act 1983 (as amended). That objective is the protection of the public and involves the pursuit of the following:

a. to protect, promote and maintain the health, safety and wellbeing of the public;
b. to maintain public confidence in the profession;
c. to promote and maintain proper professional standards and conduct for members of the profession.

136. The Tribunal was also reminded that when considering the issue of insight and remediation the Tribunal must bear in mind the guidance in the line of authorities including *Nicholas-Pillai v GMC [2009] EWHC 1048 (Admin), Towuanghantse v GMC [2021] EWHC 681* and *Sawati v General Medical Council [2022] EWHC 283 (Admin).* Maintenance of innocence at a Tribunal should not automatically result in a finding of failure of insight: it is of potential relevance but its relevance should be properly considered in context. In particular where a denied allegation involves an issue of dishonesty the Tribunal must consider whether the element of dishonest state of mind was a primary allegation and then the nature of the denial. It should also consider how far 'lack of insight' is evidenced by anything other than the

rejected defence and the nature of the defence, identifying clearly any respect in which it was itself a deception, if such is the case.

The Tribunal's Determination on Impairment

Misconduct

137. The Tribunal first considered whether the facts found proved amounted to misconduct.

138. Paragraph 1 of the Allegation was admitted and found proved. Dr Shonde thereby accepted that between February 2020 and April 2020, whilst working for LBM, he issued in excess of 1,000 prescriptions without an adequate clinical history.

139. The Tribunal also determined and found proved specific failures in relation to Dr Shonde's prescribing, at paragraphs 2ai-ii, 3, 4ai-ii, 6ai-ii, 7, 8a, 9 and 10a of the Allegation.

140. The Tribunal reminded itself of Dr B's expert opinion. She concluded that Dr Shonde's prescribing was seriously below the standard expected of a prescribing doctor. She stated that:

> *'In my opinion, prescribing Dihydrocodeine, Codeine, Co-dydramol, Remedeine Forte, Pregabalin, Amitriptyline and Co-codamol 30/500mg without the necessary clinical information was seriously below the standard expected of a prescribing doctor. In my opinion, prescribing Dihydrocodeine and other opiates online is unsafe, and that Dr Shonde prescribed it, given limited clinical information, is seriously below the standard expected of a reasonably competent prescribing doctor. In my opinion, Dr Shonde failed to take cognisance of the GMC remote prescribing sections of the Good Practice in Prescribing and Managing Medicines and Devices. In my opinion, Dr Shonde failed to take cognisance of the GMC remote prescribing sections of the Good Practice in Prescribing and Managing Medicines and Devices 2013 particularly sections 3, 9, 11, 14, 15, 21, 24, 32, 33, 37, 39, 41, 51, 52, 53, 55-61, 64 and 66 and that this could have led to patient harm. I also refer to NICE NG46 section 1.5 and GMC Good Medical Practice sections 15, 16 and 21.'*

141. Dr Shonde also accepted himself that he fell short as regards to paragraph 12 and 16(a) of GMP and paragraphs 51 and 61 of the 2013 Prescribing Guideline.

142. The Tribunal agreed that the paragraphs of the prescribing guidance and GMP as referred to by Dr B and Dr Shonde, were engaged in this case and that the matters proved contravened them. The Tribunal considered of particular relevance the following paragraphs of the GMP and the Prescribing Guidance:

GMP

'1. Patients need good doctors. Good doctors make the care of their patients their first concern: they are competent, keep their knowledge and skills up to date, establish and maintain good relationships with patients and colleagues, are honest and trustworthy, and act with integrity and within the law.

11. You must be familiar with guidelines and developments that affect your work.

12. You must keep up to date with, and follow, the law, our guidance and other regulations relevant to your work.

13. You must take steps to monitor and improve the quality of your work.

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

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

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

b) promptly provide or arrange suitable advice, investigations or treatment where necessary

c) refer a patient to another practitioner when this serves the patient's needs.

16. In providing clinical care you must:

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

b) provide effective treatments based on the best available evidence

…

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

65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession.'

Prescribing Guidance

'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.

53. Reviewing medicines will be particularly important where:

…
b) medicines have potentially serious or common side effects

c) the patient is prescribed a controlled or other medicine that is commonly abused or misused
…

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

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.'

143. The Tribunal considered that Dr Shonde failed to take due care and contravened the guidelines thereby putting patients at risk. It considered that as a senior physician, he knew or should have known, about the risks of addiction and misuse of opioids, particularly given his experience as a prisoner mentor. The Tribunal determined that Dr Shonde's actions would be regarded as 'deplorable' by fellow practitioners and concluded that his conduct fell so far short of the standards reasonably to be expected of a doctor as to amount to misconduct.

Impairment

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

145. The Tribunal had regard to the guidance in *Grant,* as set out above. It was satisfied for reasons set out above that Dr Shonde had in the past acted so as to put patients at unwarranted risk of harm.

146. In considering the likelihood of repetition of this risk of harm, the Tribunal carefully considered Dr Shonde's insight and remediation. The Tribunal was mindful that some misconduct can be difficult to remediate, however, it did consider the misconduct in this case to be remediable.

147. The Tribunal noted that in his Rule 7 Response Dr Shonde had largely denied, any shortcomings, four years after the events. At that time Dr Shonde was unrepresented and he accepted that he had been 'very bullish and defensive' and said he should 'have reflected over it' and stated that he put his response together in a limited amount of time. The Tribunal considered, however, that at this hearing he had shown insight into his actions. He had accepted and admitted the general terms of the Allegation as contained within Paragraph 1. The Tribunal had some concern with regard to his claim that he sought further relevant information where multiple opioids were requested. The Tribunal was satisfied in each of the instances it considered, that on the balance of probabilities the evidence did not show that this occurred. It does note however, that Dr Shonde states he had no recollection of individual cases, and that this was a principle and practice he had wanted to ensure was in

operation. Bearing in mind the passage of time, the evidence of several failed systems at LBM and the lack of any independent evidence as to the existence or otherwise of the protocol or safeguard, the Tribunal do not see this issue as of significance in its overall assessment of the extent of Dr Shonde's insight.

148. When it was put to Dr Shonde during his evidence in this stage that he still sought to lay the blame on Mr D and LBM for the position he found himself in, he replied that *'the blame was on me, I should have checked myself.'* The Tribunal was also mindful of Mr Gillespie's submission that Dr Shonde was entitled to provide a degree of context and that is not the same thing as passing the blame, and that what was important was Dr Shonde's insight at this point in time, and not that he gained it long ago or how long he has held it.

149. The Tribunal also noted the various courses Dr Shonde had undertaken to remediate the concerns, and the strong statements in his reflections which evidenced acceptance of his inappropriate conduct. He has resolved not to engage in the type of online prescribing which led to the concerns, which was very different from his usual medical practice then, and now. The Tribunal also bore in mind the time that had elapsed since the events and that there had been no other concerns in this period. Moreover, it noted positive patient survey feedback and strong testimonials speaking to Dr Shonde's integrity and current practice. For these reasons the Tribunal accepted Mr Gillespie's submission that there was no current risk to patients.

150. As regards to the other elements of the test in *Grant*, the Tribunal was satisfied that Dr Shonde's misconduct was serious and had put many patients at risk. As such it breached the fundamental tenet of the medical profession as set out in Paragraph 1 of GMP and thereby brought the profession into disrepute.

151. For these reasons the Tribunal determined that given the seriousness of its findings, a finding of impairment was necessary to uphold limbs (b) and (c) of the overarching objective, to maintain public confidence in the profession, and to promote and maintain proper professional standards and conduct for members of the profession.

152. Accordingly, the Tribunal determined that Dr Shonde's fitness to practise is impaired by reason of his misconduct.

Determination on Sanction - 05/08/2025

153. Having determined that Dr Shonde's fitness to practise is impaired by reason of misconduct, the Tribunal now has to decide in accordance with Rule 17(2)(n) of the Rules on the appropriate sanction, if any, to impose.

The Evidence

154. The Tribunal has taken into account evidence received during the earlier stages of the hearing where relevant to reaching a decision on sanction. It received no further evidence at this stage.

Submissions

GMC submissions

155. On behalf of the GMC, Mr Barton submitted that the appropriate and proportionate sanction was suspension.

156. Throughout his submissions, Mr Barton referred the Tribunal to the relevant paragraphs of the Sanctions Guidance (February 2024 version) ('SG').

157. Mr Barton reminded the Tribunal of the reasons for imposing sanctions, which is to achieve the statutory overarching objective. He stated the three limbs of the overarching objective and submitted that they must be considered as a whole and that no undue weight should be attached to any one limb at the expense of another.

158. Mr Barton submitted that the Tribunal must have regard to the principle of proportionality and impose the least onerous sanction necessary which achieves the overarching objective.

159. Mr Barton invited the Tribunal to consider the mitigating and aggravating factors.

160. In regard to mitigating factors, Mr Barton submitted that Dr Shonde has practised for many years and is a man of hitherto good character. He stated that although the misconduct was sustained over several weeks, it represented the only blemish on an otherwise distinguished career, had occurred five years ago and there had been no repetition or further issues. He submitted that it was clear that Dr Shonde's professional colleagues and patients hold him in high regard. He added that Dr Shonde made broad admissions at the start of the hearing in relation to his conduct and that in his statement on the facts and in his reflective

statement, Dr Shonde acknowledged and took responsibility for the majority of his failings. Mr Barton further submitted that the Tribunal had formed the view that Dr Shonde had shown insight in his evidence, and it had accepted that there was no longer any risk to patient safety.

161. Turning to potential aggravating factors, Mr Barton submitted that there had been a sustained course of conduct lasting many weeks which involved unsafe prescriptions to over a 1000 patients. He submitted that it was the view of the GMC expert, Dr B, that Dr Shonde's conduct fell seriously below the standards expected and posed a clear risk to patient safety. He submitted that the extent of any actual harm will never be known.

162. Mr Barton also reminded the Tribunal it had found there had been multiple and significant departures from GMP and the GMC Prescribing Guidance, as identified by Dr B. Mr Barton submitted that the most basic safety measures were so lacking that it must have been obvious to a senior practitioner of Dr Shonde's experience that patients were being put at risk on a daily basis, but despite that, Dr Shonde continued prescribing opioids remotely right up until the General Pharmaceutical Council (GPhC) intervened. Mr Barton also submitted that in an email to Ms A the day after the GPhC inspection Dr Shonde had tried to persuade her that LBM was operating safely and appropriately, and that Dr Shonde continued to deny any safety concerns in his Rule 7 response some 4 years later.

163. Mr Barton submitted that to take no action in this case would be inconsistent with the Tribunal's findings on impairment. He submitted that Dr Shonde's misconduct not only brought the profession into disrepute but had breached fundamental tenets of the profession. He submitted that it would be wholly inadequate to take no action.

164. Mr Barton submitted that conditions were not appropriate in this case given the serious and sustained nature of the misconduct found. He submitted that whilst it may be possible to formulate a set of conditions to address the concerns regarding Dr Shonde's prescribing, the Tribunal had found that he did not currently pose a risk in that regard and conditions would not be sufficient to ensure public confidence in the medical profession and maintain proper professional standards.

165. Mr Barton submitted that suspension was the appropriate and proportionate sanction and drew the Tribunal's attention to paragraphs 91, 92, 93 and 97 a, e, f and g of the SG.

166. Mr Barton also highlighted the guidance in the SG relevant to consideration of the length of a suspension. This included the extent of the departure from the principles of GMP,

the failure to take prompt action when patient safety was compromised, and the extent to which the actions risked patient safety and public confidence. Mr Barton submitted that in this case a period of suspension at the upper end of the Tribunal's discretion would be appropriate and proportionate.

167. Mr Barton submitted that a review hearing would be appropriate in this case. He submitted that it would allow a reviewing Tribunal to consider whether Dr Shonde had fully appreciated the gravity of his actions, ensure he had not engaged in any similar behaviour and confirm he had maintained his skills and knowledge over the period of suspension.

168. Whilst Mr Barton submitted that suspension was the appropriate and proportionate sanction, he also addressed the Tribunal on erasure and drew the Tribunal's attention to paragraphs 107, 108, and the factors outlined at paragraph 109 which indicate when erasure might be appropriate. However, he submitted that this was not a case where only erasure would suffice and that it falls plainly within the guidance where suspension would meet the seriousness of the case.

169. Mr Barton also referred the Tribunal to the paragraphs 172 and 173 of the SG which advise when an immediate order might be necessary. He submitted that in light of the Tribunal's findings that Dr Shonde does not pose a current risk to patients, an immediate order would not be sought in this case.

Submissions on behalf of Dr Shonde

170. On behalf of Dr Shonde, Mr Gillespie's primary submission was that the Tribunal could take no action in this case.

171. Mr Gillespie agreed that conditions would not be appropriate. He submitted that the finding of impairment did not relate to patient safety and that it was difficult to see what particular areas of practice conditions would be framed to address.

172. Mr Gillespie also agreed that erasure would be disproportionate.

173. Mr Gillespie submitted that there were therefore two options available to the Tribunal; to take no action or to impose a sanction of suspension.

174. Mr Gillespie submitted that where there has been a finding of impairment, it will usually be necessary to take action but that there may be exceptional circumstances to justify

a tribunal taking no action. He submitted that exceptionality is not a 'ridiculously high bar' but something which is out of the norm, but which can be justified.

175. Mr Gillespie submitted that the misconduct happened five years ago, there has been no repetition in that period. He submitted that the finding of impairment may in fact be sufficient to mark the gravity of the case.

176. Mr Gillespie submitted that the seriousness of what has been proved was not disputed and that it was accepted that there was a risk to a very substantial number of patients, whether or not that risk eventuated.

177. With regards to mitigating factors, Mr Gillespie directed the Tribunal to the examples of mitigating factors outlined at paragraph 25 of the SG. He submitted that Dr Shonde understands the problem, has insight and that there has been remediation. He reminded the Tribunal that it had found that there are no concerns about Dr Shonde's current safety to practise, and that he is working to an extremely high level. Mr Gillespie also stressed the significant length of time since the incident and that Dr Shonde had been under investigation for a considerable period of that time. He also noted the circumstances leading up to the incident, that Ms A saw, or was told something, which was sufficient to permit her to recommend inclusion of LBM to the register, and Dr Shonde's reliance on that. Mr Gillespie submitted that whilst this did not absolve Dr Shonde from his obligations to follow guidance it was an important contextual feature.

178. In regard to aggravating factors, Mr Gillespie submitted that it follows that a lack of insight would not be an aggravating factor in this case. He also confirmed that there had been no previous finding of impairment. He submitted that the only relevant issue was the question of whether the patients were vulnerable or not as the SG advises that where a patient is vulnerable, there is an even greater duty on doctors to safeguard them. Mr Gillespie submitted that this was impossible to determine because of the lack of information about the patients.

179. Mr Gillespie accepted that insight and remediation were not likely to be exceptional on their own. However, he highlighted the length of time since the events arose, the fact that there was nothing before nor since and the unusual circumstances in which it arose. He submitted that whilst it was accepted that the safeguards were inadequate it was not a case of a doctor prescribing opioids without any thoughts or any safeguards. He also submitted that Dr Shonde's motivation was not self-centred and there was no evidence he did it for financial gain.

180. Mr Gillespie submitted that Dr Shonde has kept his knowledge and skills up to date. He also reminded the Tribunal of the voluntary work Dr Shonde does in Nigeria and with prisoners. He submitted that Dr Shonde is a good doctor who is highly thought of in his field and he reminded the Tribunal that there is a public interest in allowing good doctors to practise medicine. Mr Gillespie submitted that given the Tribunal's previous factual findings and finding of impairment, together with the publication of these findings, this was sufficient to mark the seriousness of this case and to send the relevant message to Dr Shonde, the public and other members of the profession.

181. Mr Gillespie accepted that the Tribunal may find that it is not sufficient to take no action and referred it to the paragraphs of the SG which advise when suspension may be appropriate. He noted that suspension may have a punitive effect but submitted that it would not cause unnecessary hardship to Dr Shonde. He submitted that paragraph 93 of the SG was particularly relevant. He submitted that the Tribunal can be satisfied that the behaviour is unlikely to be repeated and that the process has been a salutary experience for Dr Shonde and that he has reflected extensively and realised that what he did was wholly inappropriate. Mr Gillespie also stressed that the work Dr Shonde was doing for LBM was completely different from his normal practise in which he does not prescribe opioids unless there has been some event which requires acute treatment.

182. Mr Gillespie submitted that if the Tribunal were to go down the suspension route then a review hearing would not be necessary. He submitted that this was because the Tribunal had found that there was insight, that Dr Shonde has remediated and that there are no concerns about patient safety. He submitted that it was difficult to see what would be the aim and purpose of any review and that it was unlikely Dr Shonde would become deskilled in any period of suspension.

183. Mr Gillespie also accepted that paragraph 97a, e, f and g were important features in this case.

184. Mr Gillespie acknowledged that the Tribunal should also do a 'sense check' and look at the guidance for erasure. He noted that the factors outlined in the SG which advise when erasure might be appropriate and submitted that it was not a case where Dr Shonde has shown a blatant disregard for safeguards as he had plainly had safeguards in mind. He also submitted that the Tribunal had found that the behaviour was remediable and has been remedied.

185. Turning back to suspension, Mr Gillespie submitted that any period should be no longer than is necessary to send out the appropriate message. He submitted that taking everything in the round, the Tribunal was entitled to impose a short period of suspension in this case.

186. In summary, Mr Gillespie submitted that the Tribunal could consider taking no action but if it determined that suspension was appropriate, then the proportionate response would be a short period with no review. He also added that this was not a case where an immediate order of suspension should be imposed as there is no risk to patient safety.

The Relevant Legal Principles

187. The Tribunal had regard to the SG and bore in mind that the main purpose of imposing a sanction is to uphold the overarching objective.

188. The Tribunal should consider each sanction starting from the least restrictive. It bore in mind that sanctions are not intended to be punitive but may have a punitive effect.

189. Throughout its deliberations the Tribunal also had regard to the principle of proportionality, balancing the interests of Dr Shonde with the public interest. The Tribunal bore in mind that the reputation of the profession as a whole is more important than the interests of any individual doctor. The Tribunal was reminded of the principle in *Bolton v Law Society [1994] 1 WLR 512.* The privileges of being a member of a profession also carry responsibility and a sanction may be necessary even when there may not be a risk of repetition.

The Tribunal's Determination on Sanction

Aggravating & Mitigating Factors

190. The Tribunal first considered the aggravating and mitigating factors present in this case.

191. The Tribunal considered the following to be aggravating factors:

- Dr Shonde's misconduct was sustained over many weeks. He issued in excess of 1,000 prescriptions, failed to obtain an adequate clinical history and more than 80% of

these prescriptions were opioid related. He continued until he was stopped by the General Pharmaceutical Council and did not raise concerns himself;

- Although the Tribunal found that Dr Shonde currently has insight, this was slow developing and even at the point of the Rule 7 response he was maintaining that the practice was safe;
- With regards to potential vulnerability of the patients, Dr B told the Tribunal that there were strong red flags indicating potential drug seeking behaviour within the questionnaires which should have alerted Dr Shonde to potential vulnerability.

192. The Tribunal considered the following to be mitigating factors:

- Dr Shonde displayed a good level of developing insight by the time of the Tribunal. He had made broad admissions and took responsibility for the majority of the allegations against him. He had also remediated the concerns to an extent whereby the Tribunal had found no ongoing risk to patients;
- Dr Shonde is an otherwise competent doctor practising safely and held in high regard by colleagues and patients. There is no previous fitness to practise history and the misconduct, although sustained over six weeks, is the only matter of concern over decades of unblemished practise.

193. The Tribunal noted the submission that the context behind the misconduct could be mitigating. It was submitted by Mr Gillespie that Ms A had accepted the protocol or risk assessment that Dr Shonde had helped prepare. The Tribunal noted that in her evidence Ms A stated that she had been satisfied via documentary and 'verbal assurances.' There was no evidence of what was contained in any protocol or that it was put into action. The Tribunal considered Dr Shonde's reliance on Ms A's implicit approval to be of limited mitigation.

No action

194. The Tribunal first considered whether to conclude the case by taking no action. Taking no action after a finding of impaired fitness to practise is appropriate only in exceptional circumstances. Paragraph 70 of the SG advises that exceptional circumstances are *'unusual, special or uncommon, so such cases are likely to be rare.'*

195. The Tribunal took into account Dr Shonde's insight, remediation, the lapse of time since the events with no repetition, the context surrounding the misconduct and that it occurred outside Dr Shonde's usual sphere of practice and that there was no financial gain on his part. The Tribunal considered that these were not exceptional circumstances that would

justify taking no action. It considered that to take no action would neither be proportionate nor in the public interest, given the serious nature of Dr Shonde's misconduct, in particular the risk of harm to patients.

Conditions

196. The Tribunal next considered whether to impose conditions on Dr Shonde's registration. Neither Counsel submitted that the Tribunal should impose conditions in this case.

197. The Tribunal found that there were no patient safety concerns and considered that there were no specific deficiencies in Dr Shonde's medical practice which could be addressed via conditions. Moreover, the Tribunal considered that conditions would fail to mark the seriousness of its findings and would be insufficient to maintain public confidence in the medical profession and to uphold proper professional standards.

Suspension

198. The Tribunal next considered whether to impose a sanction of suspension.

199. The Tribunal considered that the following paragraphs of the SG were particularly relevant in this case:

> *91. Suspension has a deterrent effect and can be used to send out a signal to the doctor, the profession and public about what is regarded as behaviour unbefitting a registered doctor. Suspension from the medical register also has a punitive effect, in that it prevents the doctor from practising (and therefore from earning a living as a doctor) during the suspension, although this is not its intention.*
>
> *92. Suspension will be an appropriate response to misconduct that is so serious that action must be taken to protect members of the public and maintain public confidence in the profession. A period of suspension will be appropriate for conduct that is serious but falls short of being fundamentally incompatible with continued registration (ie for which erasure is more likely to be the appropriate sanction because the tribunal considers that the doctor should not practise again either for public safety reasons or to protect the reputation of the profession).*

93. Suspension may be appropriate, for example, where there may have been acknowledgement of fault and where the tribunal is satisfied that the behaviour or incident is unlikely to be repeated. The tribunal may wish to see evidence that the doctor has taken steps to mitigate their actions.

97. Some or all of the following factors being present (this list is not exhaustive) would indicate suspension may be appropriate.

a) A serious departure from Good medical practice, but where the misconduct is not so difficult to remediate that complete removal from the register is in the public interest. However, the departure is serious enough that a sanction lower than a suspension would not be sufficient to protect the public.

…

e) No evidence that demonstrates remediation is unlikely to be successful, eg because of previous unsuccessful attempts or a doctor's unwillingness to engage.

f) No evidence of repetition of similar behaviour since incident.

g) The tribunal is satisfied the doctor has insight and does not pose a significant risk of repeating behaviour

200. The Tribunal considered that a period of suspension could mark the seriousness of the conduct and could be used as a signal to Dr Shonde, the profession and the public about what is regarded as behaviour unbefitting of a registered doctor.

201. The Tribunal considered that the misconduct in this case was so serious that no sanction less than suspension would be sufficient to uphold the overarching objective. Having found the misconduct was serious the Tribunal went on to consider whether it was fundamentally incompatible with continued registration.

202. The Tribunal considered the paragraphs of the SG which advise when erasure might be appropriate. In particular it noted the following paragraphs:

108. Erasure may be appropriate even where the doctor does not present a risk to patient safety, but where this action is necessary to maintain public confidence in the profession. For example, if a doctor has shown a blatant disregard for the safeguards designed to

protect members of the public and maintain high standards within the profession that is incompatible with continued registration as a doctor.

109. Any of the following factors being present may indicate erasure is appropriate (this list is not exhaustive).

a) A particularly serious departure from the principles set out in Good medical practice where the behaviour is difficult to remediate.

b) A deliberate or reckless disregard for the principles set out in Good medical practice and/or patient safety.

203. Whilst the Tribunal found that there had been particularly serious departures from the principles set out in GMP, it found that the misconduct was remediable and had been remediated. And whilst the Tribunal considered that the misconduct was a reckless disregard for the principles set out in GMP, it considered that this may have been borne out of naivety when Dr Shonde strayed from his usual scope of practice, albeit he should have been aware of the risks.

204. The Tribunal considered that the misconduct was not fundamentally incompatible with continued registration and that erasure would be disproportionate. The Tribunal was satisfied that in all the circumstances of this case that suspension was the appropriate sanction.

Duration of Suspension

205. The Tribunal went on to consider the appropriate length of suspension, taking account of guidance from paragraphs 99 of the SG.

206. Paragraph 100 of the SG advises that:

100 The following factors will be relevant when determining the length of suspension:

- *a) the risk to patient safety/public protection*
- *b) the seriousness of the findings and any mitigating or aggravating factors…*
- *c) ensuring the doctor has adequate time to remediate.*

207. The Tribunal found that key factor in determining the length of the suspension was the seriousness of the misconduct as established and the significant risk of harm involved, taking into account all the aggravating and mitigating factors as set out earlier.

208. The Tribunal determined to impose a sanction of suspension for a period of 9 months. It considered that a lengthier period would be disproportionate given all the circumstance of this case but that a shorter period would be insufficient to mark the gravity of the misconduct found.

Review

209. The Tribunal determined to direct a review hearing. In so doing, it considered paragraph 164 to be relevant:

> *164 In some misconduct cases it may be self-evident that, following a short suspension, there will be no value in a review hearing. However, in most cases where a period of suspension is imposed, and in all cases where conditions have been imposed, the tribunal will need to be reassured that the doctor is fit to resume practice – either unrestricted or with conditions or further conditions. A review hearing is therefore likely to be necessary, so that the tribunal can consider whether the doctor has shown all of the following (by producing objective evidence):*
>
> *a) they fully appreciate the gravity of the offence*
> *b) they have not reoffended*
> *c) they have maintained their skills and knowledge*
> *d) patients will not be placed at risk by resumption of practice or by the imposition of conditional registration.*

210. The Tribunal was satisfied that a sanction of suspension for a period of 9 months with a review was necessary to promote and maintains public confidence in the profession and promote and maintain proper professional standards and conduct for members of the profession.

211. A review hearing will convene shortly before the end of the period of suspension. The Tribunal wishes to clarify that at the review hearing, the onus will be on Dr Shonde to demonstrate that he has continued to develop insight and has maintained his clinical skills and kept his knowledge up to date. It therefore may assist the reviewing tribunal if Dr Shonde provides evidence of further reflections and continuing professional development along with any other information that he considers might assist the reviewing tribunal.

Determination on Immediate Order - 05/08/2025

212. Having determined that Dr Shonde's registration be subject to period of suspension, the Tribunal has considered, in accordance with Rule 17(2)(o) of the Rules, whether Dr Shonde's registration should be subject to an immediate order.

Submissions

213. Mr Barton indicated in his submissions on Sanction that an immediate order was not sought in this case. He had referred the Tribunal to paragraphs 172 and 173 of the SG and submitted that in light of the Tribunal's findings that Dr Shonde does not currently pose a risk to patients, an immediate order was not necessary.

214. On behalf of Dr Shonde, Mr Gillespie also submitted that an immediate order should not be imposed as there is no risk to patient safety.

The Tribunal's Determination

215. In reaching its decision, the Tribunal had regard to the relevant paragraphs of the SG which advise when an immediate order might be necessary. In particular it had regard to the following paragraphs:

> *'172 The tribunal may impose an immediate order if it determines that it is necessary to protect members of the public, or is otherwise in the public interest, or is in the best interests of the doctor. The interests of the doctor include avoiding putting them in a position where they may come under pressure from patients, and/or may repeat the misconduct, particularly where this may also put them at risk of committing a criminal offence. Tribunals should balance these factors against other interests of the doctor, which may be to return to work pending the appeal, and against the wider public interest, which may require an immediate order.*
>
> *173 An immediate order might be particularly appropriate in cases where the doctor poses a risk to patient safety. For example, where they have provided poor clinical care or abused a doctor's special position of trust, or where immediate action must be taken to protect public confidence in the medical profession.*
>
> *…*
>
> *178 Having considered the matter, the decision whether to impose an immediate order will be at the discretion of the tribunal based on the facts of each case. The tribunal should consider the seriousness of the matter that led to the substantive*

direction being made and whether it is appropriate for the doctor to continue in unrestricted practice before the substantive order takes effect.'

216. The Tribunal bore in mind that there were no concerns that Dr Shonde poses a current risk to patient safety, and it considered therefore that an immediate order was not necessary to protect members of the public. It also noted that Dr Shonde had continued to practise without concern since the events. As to whether an immediate order was otherwise in the public interest, the Tribunal considered that this was already served by the Tribunal's finding of impairment and its determination to impose a substantive sanction of suspension. The Tribunal also considered that there was no information to suggest an immediate order was in the best interests of Dr Shonde. Accordingly, the Tribunal determined not to impose an immediate order.

217. This means that Dr Shonde's registration will be suspended from the Medical Register 28 days from the date on which written notification of this decision is deemed to have been served, unless he lodges an appeal. If Dr Shonde does lodge an appeal he will remain free to practise unrestricted until the outcome of any appeal is known.

218. There is no interim order to be revoked.

219. The concludes the case.

ANNEX A – 24/07/2025

Application under Rule 17(2)g

220. Following the close of the GMC's case, Mr Gillespie, on behalf of Dr Shonde, made an application pursuant to Rule 17(2)(g) the Rules of 'no case to answer' in relation to paragraphs 4b, 5, 6b, 8b, 10b, 12 and 13 of the Allegation.

221. Rule 17(2)g provides that:

> *'17(2) The order of proceedings at the hearing before a Medical Practitioners Tribunal shall be as follows—*
> *…*
> *(g) the practitioner may make submissions as to whether sufficient evidence has been adduced to find some or all of the facts proved and whether the hearing should proceed no further as a result, and the Medical Practitioners Tribunal shall consider any such submissions and announce its decision as to whether they should be upheld;'*

222. In summary, Mr Gillespie submitted that the GMC had adduced insufficient evidence to prove the allegations, and he invited the Tribunal to decide that these paragraphs of the Allegation should go no further.

223. Both parties provided written submissions in relation to the application and made oral submissions to the Tribunal.

Submissions on behalf of Dr Shonde

224. Mr Gillespie reminded the Tribunal that it should take into account the evidence that has been adduced and the test to be applied as set in *in R v Galbraith [1981] 2 All ER 1060.* Mr Gillespie also referred the Tribunal to the case of *Husband v GDC [2019] EWHC 2210 (Admin)* where the court confirmed that it is incumbent on the Tribunal to consider the whole of the evidence which has been produced at the stage of the no case to answer application and the task for it is to decide whether the charge could be made out, not whether it would be made out.

225. Mr Gillespie submitted that the documentary evidence points one way in this case and that a properly directed tribunal could not find these particular allegations to be proved to the required standard.

226. Mr Gillespie submitted that there are three sets of documents which need to be considered together: the order or request for medication; the prescription signed by Dr Shonde; and the private prescription register ('the register').

227. Mr Gillespie submitted that whilst the dates on the register entries may not exactly coincide with the dates on the prescription and the dates of dispensing, this was not surprising; the evidence given thus far had been that the prescription date and the dispensing date frequently are not the same for a variety of reasons.

228. Mr Gillespie accepted that in each instance the subject of this application it is accepted that what the patient requested appears on the face of the prescription, including two opioids. However, he submitted that in each case, instructions are written against only one of the opioids and, in each case, except in the case of Patient O (where there was no apparent entry in the register), what is recorded on the register as having been dispensed coincides exactly with only those for which there are instructions on the prescription.

229. Mr Gillespie submitted that there is no evidence anywhere in the register of the same patient actually being supplied with two opioids on the same occasion. He also highlighted that where instructions were given for two medications, such as in the case of Patient A, the two medications were prescribed.

230. Mr Gillespie clarified that his submissions do not concern the appropriateness of any prescription, whether there were any ''red flags'', what the risk was of a locum pharmacist being unsure what was to dispense, nor whether the system or software in use was safe or any other such issue. He submitted that the only issue at this stage is whether there is sufficient evidence upon which a Tribunal could find that two opioids had been prescribed to the same patient on the same occasion.

231. Mr Gillespie submitted that in relation to Patient H, the words *"Zapain only"* appear on the prescription, and in relation to Patient M there is a cross next to the words *"Remedeine Forte"*. He also submitted that in relation to Patient P the word *''No''* appears next to the word *''Dihydrocodeine''*. He submitted that none of these drugs are dispensed.

232. Mr Gillespie submitted that the GMC's case was that because in each case the drugs as requested appear on the prescription, an inference can be drawn that that all these drugs were actually prescribed. However, he submitted that in relation to Patient H, M and P, there is positive evidence on the face of the prescription that only one opioid was prescribed and,

therefore, there is no evidence at all that the prescription was for both the opioids requested.

233. Mr Gillespie submitted that in every case, the only opioid that was dispensed was that for which instructions had been added. He submitted that there is no evidence that this was because of any intervention by another, such as a pharmacist checking with Dr Shonde and submitted that it would be too much of a coincidence were it to be the case that on each occasion:

i) Dr Shonde prescribed two opioids, or in the case of Patient K three opioids, but only gave instructions for one
ii) There was an intervention by someone else at the pharmacy
iii) As a result of that intervention, what was dispensed in all cases was only that opioid for which instructions had been given in the first place.

234. Mr Gillespie submitted that the amount charged to the patient was not evidence that supports multiple prescribing. He submitted Ms A gave clear evidence that it is common for online pharmacies to take money upfront and then refund the patient after the prescription is issued or the medication dispensed.

235. Mr Gillespie submitted that, looking at the evidence as a whole, the only proper inference that can be drawn is that Dr Shonde only prescribed those drugs for which he had given instructions and that was the understanding of those who dispensed the medication. He submitted that no other inference makes sense or is justified on the evidence. He added that the fact that the request is repeated on the prescription is not sufficient evidence in the circumstances of this case to find a case to answer.

236. Mr Gillespie referenced Ms A's evidence that had she seen these prescriptions she would want to ask the pharmacy further questions about their systems. He submitted that the Tribunal has the advantage of having actually seen the documentation as a whole and was able to the put the picture together.

237. Mr Gillespie submitted that the idea that somebody on each of these occasions intervened to get further clarity before prescribing the opioid, which on each occasion was the only one that had instructions next to it, was 'absolutely fanciful' and not a proper inference that can be drawn. He submitted that there was simply no evidence of any intervention.

238. In summary, Mr Gillespie submitted that there is no, or wholly insufficient evidence, in relation to these applications for them to proceed to be answered by Dr Shonde, and accordingly he invited the Tribunal to dismiss them.

GMC submissions

239. On behalf of the GMC, Mr Barton submitted that the Tribunal should refuse the application.

240. Mr Barton submitted that the prescriptions were analagous to face-to-face prescriptions in the sense that a piece of paper can be handed to a patient who must then go to a pharmacy to obtain the drug. He submitted that Dr Shonde was providing authorisation by signing the document.

241. Mr Barton submitted that the second limb of the *Galbraith* test was in issue in this case, which states:

> *'(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence. (a) Where the judge concludes that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict on it, it is his duty, on a submission being made, to stop the case. (b) Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness's reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury"*

242. Mr Barton stressed that the test was whether on one possible view of the facts a tribunal *could* find it proved to the civil standard of proof, not whether it would.

243. Mr Barton also referred the Tribunal to the case of *McLennan v. General Medical Council [2020] CSIH 12 61.17* which deals with the issue of 'sufficiency of evidence' at the half time stage. In this it was stated that:

> '*Sufficiency of evidence is not about whether one version of events is more or less probable than another. It is whether, on the evidence already led at that stage of the*

proceedings, a Tribunal would be entitled to draw the inference that the facts, which form the allegation, have been proved.'

244. Mr Barton submitted that the Tribunal is not permitted at this stage to consider any explanation advanced by Dr Shonde in his statements provided to the Tribunal. He submitted that it may be that if Dr Shonde chooses to give evidence at the next stage the Tribunal may give weight to that explanation, but it simply does not arise at this stage. Mr Barton submitted that the Tribunal must resist the temptation to speculate as to possible explanations for the possible inconsistency between the prescriptions and other documentation.

245. Mr Barton submitted that when considering the sufficiency of that evidence, the key phrase from the *Galbraith* test is *"where on one possible view of the facts there is evidence on which the jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury".*

246. Mr Barton submitted that in each of the allegations that fall to be considered the particulars allege that Dr Shonde ''prescribed'' or ''issued a prescription''. In each case there are prescriptions issued by Dr Shonde, signed and dated by him, for double doses of opioids. He submitted that on the face of those documents, it appears that the patient has been billed and paid for both sets of drugs, and there is no apparent evidence of any subsequent refund.

247. Mr Barton submitted that this represents clear and sufficient evidence that Dr Shonde prescribed each of the opioids in question and applying the relevant test there is a case to answer at this stage.

248. Mr Barton submitted that the submission on behalf of Dr Shonde relies heavily upon a particular interpretation of the prescription register. He noted that in Ms A's evidence, she stated that these were provided to her by the Superintendent Pharmacist at Letterbox Meds as part of the evidence she collated for her inspection report. He submitted that there is no clear evidence as to who created these records and in what circumstances. He submitted that the entries do not contain the unique prescription order number which would allow for a precise cross reference with the prescriptions themselves, and that the register entries are also not always on exactly the same days as the date the prescription was issued.

249. Mr Barton also submitted that there are anomalies within the register, noting the prescriptions to Patient A and Patient O do not appear at all. He submitted that even if the

Tribunal were to accept that this register represents an accurate record of what was actually supplied to the patient, it is not necessarily evidence as to what was prescribed by Dr Shonde.

250. Mr Barton submitted that Ms A had stated in evidence that there appeared to be a subsequent ‘‘intervention’’ at some point to prevent the supply of two opioids. He submitted that not only is there no evidence at all as to what that intervention was, it is not established that it was Dr Shonde’s annotations regarding instructions and does not show that Dr Shonde did not prescribe two opioids as alleged.

251. Mr Barton submitted that at this stage, the signed prescriptions themselves represent clear and sufficient evidence of double opioid prescribing by Dr Shonde as has been alleged. He submitted that in applying the relevant test there is therefore a case to answer at this stage.

The Tribunal’s approach

252. The Tribunal reminded itself that, at this stage, its purpose was not to make findings of fact but to determine whether sufficient evidence, taken at its highest, had been presented by the GMC such that a properly directed Tribunal could find the relevant paragraphs proved to the civil standard. The Tribunal considered the submissions made by both parties and had regard to all the evidence adduced by the GMC.

253. In considering whether sufficient evidence had been adduced to find these paragraphs of the Allegation proved, the Tribunal had regard to test as set out in *R v Galbraith [1981] 2 All ER 1060:*

> *‘(1) If there is no evidence that the crime alleged has been committed by the defendant, there is no difficulty. The judge will of course stop the case.*
>
> *(2) The difficulty arises where there is some evidence but it is of a tenuous character, for example, because of inherent weakness or vagueness or because it is inconsistent with other evidence.*
>
> *(a) Where the judge comes to the conclusion that the prosecution evidence, taken at its highest, is such that a jury properly directed could not properly convict upon it, it is his duty, upon a submission being made, to stop the case.*

(b) *Where however the prosecution evidence is such that its strength or weakness depends on the view to be taken of a witness' reliability, or other matters which are generally speaking within the province of the jury and where on one possible view of the facts there is evidence upon which a jury could properly come to the conclusion that the defendant is guilty, then the judge should allow the matter to be tried by the jury.'*

The Tribunal's Decision

254. The Tribunal first considered paragraph 4b of the Allegation which alleges that on 6 March 2020 Dr Shonde issued a prescription for codeine and zapain to Patient G for lower back pain, which was inappropriate as he prescribed more than one codeine-based opioid to Patient G when there was no clinical reason to do so.

255. The Tribunal noted that the issue challenged was that two opioids were in fact prescribed. For the purposes of this application there was no challenge that there was no clinical reason to justify it.

256. The Tribunal had regard to the prescription for Patient G, dated 6 March 2020. It noted that under the heading 'Prescription Drug' were listed both codeine and zapain and there were details regarding pack size and dosage. It also included Dr Shonde's name as the prescriber, his GMC number, and his signature.

257. Next to 'Instructions' on the prescription it stated *'Zapain – One to Two tablets every four hours to a maximum dosage of 8 tablets daily'.*

258. The Tribunal considered that given two opioids were listed, there was evidence to support the allegation that both drugs were prescribed. Further, the invoice from Letterbox Meds to Patient G, dated 6 March 2020, indicated that codeine and zapain were invoiced and paid for, and this also included the shipping cost rate for the prescriptions, the payment method and patient's billing address.

259. The Tribunal bore in mind that the script register appeared to show that only one opioid was issued/dispensed. It was mindful, however, that there is no evidence before the Tribunal as to why only one opioid was issued.

260. In relation to Patient G, Ms A stated in her evidence that if she had seen that prescription for the first time she would be asking the pharmacy what intervention had been made because looking at that prescription:

> *'' [from] a pharmacist's point of view, that would look to me that the prescription was for codeine and zapain, so I would be asking the pharmacist or the pharmacy team to check back to see if they've made any interventions and dig down into the reason why they weren't both supplied of the prescription… it looks like two prescription items that are on that prescription form and somewhere between that being issued and the prescription being dispensed, there's an intervention somewhere. But I don't know who made that intervention…'*

261. The Tribunal considered Mr Gillespie's submission that the only natural inference is that it was the way Dr Shonde created the prescription which caused the issue of only one opioid, and that it was 'fanciful' to assume that in each instance where Dr Shonde had prescribed two there had been a fortunate third-party intervention which caused only one to be issued.

262. The Tribunal considered that in the absence of positive indications as to what was the cause of only one opioid being issued, there was evidence, which taken at its highest, would allow a tribunal to conclude on the balance of probabilities that Dr Shonde had indeed prescribed two opioids. Irrespective of what was issued, Dr Shonde wrote a prescription containing reference to two opioids both of which were billed and paid for. The Tribunal was mindful of Ms A's evidence that in online pharmacy practice, it is standard for the patient to pay upfront and then to be refunded if the prescription was not met in full for whatever reason. However, the Tribunal also bore in mind, as stressed by Mr Barton, that it should not speculate where the evidence ended.

263. The Tribunal therefore refused the application in relation to paragraph 4b of the Allegation. It considered that the same reasoning applies to paragraphs 5, 6b, 8b,10b and 13 of the Allegation, relating to Patients H, I, K, M and P. In regard to paragraph 12 of the Allegation, relating to Patient 0, the Tribunal had heard in submissions that there was no apparent record in the register of what was actually dispensed. Since submissions the Tribunal has been provided with an email dated 23 July 2025 which refers the Tribunal to the relevant page in the bundle; there is a corresponding reference on the register which shows that only one opioid, codeine, was dispensed. It had been incorrectly identified as related to 'Patient N' but this has been corrected to 'Patient O'. This means that the situation as regards Patient O is no different to Patient H, I, K, M and P.

264. The Tribunal also considered Mr Gillespie's submissions in relation to Patients H, M and P. He had highlighted in the instructions on Patient H's prescription it recorded '*Zapain only…'*. In relation to Patient M, he highlighted that under 'Prescription Drug' Dr Shonde had put an *'X'* next to the drug 'Remedeine Forte'. And on Patient P's prescription under 'Prescription Drug' he had put *'No'* next to Dihydrocodeine. Mr Gillespie had also submitted that the register showed that none of these drugs had been dispensed.

265. Notwithstanding that, the Tribunal bore in mind these patients were still invoiced the full amount for both the drugs that appeared on the prescription, and it would have been open to Dr Shonde to have taken more explicit action to indicate he was not prescribing in relation to one of the opioids had he chosen to do so. Bearing in mind the seriousness of any prescription for controlled drugs a tribunal may expect it to be much more clear if the intention was to prevent them being dispensed. The Tribunal considered that if there was a system by which Dr Shonde was indicating to those issuing the drugs that one of the drugs listed on the prescription to which he had put his name should not be dispensed, it was not apparent on the evidence currently available. The Tribunal was satisfied therefore that taken at its highest, the evidence could support these allegations being found proved.

266. Accordingly, the Tribunal refused Mr Gillespie's application under Rule 17(2)g of the Allegation.

Schedule 1

Patient	Date of prescription	Medication	Quantity
Patient A	19 February 2020	Pregabalin Dihydrocodeine	200mg x 84 30mg x 100
Patient B	19 February 2020	Dihydrocodeine	30mg x 100
Patient C	19 February 2020	Codeine	30mg x 100
Patient D	21 February 2020	Dihydrocodeine	30mg x 100
Patient E	22 February 2020	Dihydrocodeine	30mg x 100
Patient F	26 February 2020	Co-codamol	30/500mg x 100
Patient G	6 March 2020	Co-codamol (Zapain) Codeine	30mg x 100 30/500 X 100
Patient H	9 March 2020	Co-codamol (Zapain) Codeine	30/500mg x 100 30mg x 100
Patient I	14 March 2020	Codeine and Dihydrocodeine	30mg x 100
Patient J	15 March 2020	Dihydrocodeine	30mg x 100
Patient K	16 March 2020	Dihydrocodeine Co-dydramol Codeine Naproxen	30mg x 28 500mg x 100 30mg x 28 250mg x 56
Patient L	27 March 2020	Codeine and Amitriptyline	30mg x 100 10mg x 28
Patient M	31 March 2020	Remedeine Forte Co-codamol	30/500 x 56 30/500mg x 100
Patient O	2 April 2020	Codeine and Dihydrocodeine	30mg x 100
Patient P	3 April 2020	Codeine and Dihydrocodeine	30mg x 100

Schedule 2 – Patient D

Trapped and bulging discs in lumbar region

Trapped nerve right sacroiliac joint

Schedule 3 – Patent F

Fibromyalgia

Migraines

Schedule 4 – Patient G

Lower back pain

Schedule 5 – Patient H

Hips, knees, elbows and belly pain caused by arthritis for the past ten years
Alport's syndrome

Schedule 6 – Patient I

Left-sided chest wall and back pain

Schedule 7 – Patient J

Torn rotator cuff

Schedule 8 – Patient K

Back pain

Schedule 9 – Patient L

Fractured fibula

Schedule 10 – Patient M

Back pain

Schedule 11 – Patient O

Lower back pain

Schedule 12 – Patient P

Arthritis in ankle
'Dodgy' knee
Abnormal spine problem
Left-sided pain