**Date of Hearing:** 6-9 January 2003

**Name of respondent doctor:** Joseph Chikelue OBI

**Registered Qualifications:** MB BS 1991 Benin

**Registered address:** Gateshead, Tyne & Wear

**Panel:**
Dr M Vaile (Chairman)
Mrs M Kakar
Dr A Montgomery
Dr R Scott
Mr D Smith

**Legal Assessor:** Nigel Parry

**Committee Secretary:** Zaheda Khan

**Type of Case:** New Conduct

**Representation:**
GMC:
Mr Nicholas Braslavsky (QC), instructed by Addleshaw Booth & Co Solicitors

Doctor:
Dr Obi was not present and was not represented.

**Charge:**

"That being registered under the Medical Act,

'1. a. On or about 1 to 3 April 2000 you were employed by Harrogate Health Care Trust as a Locum Senior House Officer, **Found Proved**

b. .....,

c. i. on 2 April 2000 a patient was admitted to the Coronary Care Unit with an acute myocardial infarction, **Found Proved**

ii. you failed to prescribe analgesia for the patient further to that provided by the Accident & Emergency Department, **Found Proved**

iii. you failed to initiate thrombolysis although this was clinically indicated, **Found Proved**

iv. you failed to seek advice from senior colleagues when it was appropriate and necessary for you to do so, **Found Proved**

d. You failed to attend and conduct an out-patient clinic for Dr D on 3 April 2000 without adequate notice or explanation,
**Found Proved**

e. Your conduct as described in heads 1c to 1d above

i. was inappropriate, **Found Proved (in relation to Heads of charge 1ci, ii, iii and iv) Found Not Proved (in relation to Head of Charge 1d)**

ii. was unprofessional, **Found Proved (in relation to Heads of charge 1ci, ii, iii and iv) Found Not Proved (in relation to Head of Charge 1d)**

iii. put a patient at risk; **Found Proved (in relation to Heads of charge 1ci, ii, iii and iv) Found Not Proved (in relation to Head of Charge 1d)**

'2. a. Between August 2000 and December 2000 you were employed by South Tyneside Healthcare Trust as a Senior House Officer,
**Found Proved**

b. i. on 20 October 2000 Mr P brought his wife to the Accident & Emergency Department of South Tyneside District Hospital for treatment for an acute episode of a long term psychiatric disorder, **Found Proved**

ii. you said to him "We can't admit her for talking" and "If you can't stand it move out", **Found Proved**

iii. your comments were

a. insensitive, **Found Proved**

b. offensive, **Found Proved**

c. i. on 25 October 2000, you were requested to assess a patient who was considered to be at risk of self-harm,
**Found Proved**

ii. when first asked to attend, you refused,
**Found Not Proved**

iii. a senior house officer telephoned you to discuss the matter but you put the telephone down on him,
**Found Not Proved**

iv. after you had attended the patient, you wrote inappropriate notes about the duty medical team in his medical record, **Found Proved**

d. i. on 29 November 2000 you were informed South Tyneside District Hospital switchboard would pass emergency calls to you because a member of staff was off sick, **Found Not Proved**

ii. on 29 November 2000 you responded to switchboard staff in an unhelpful and offensive manner on the telephone and at the hospital switchboard, **Found Proved**

e. i. on 6 October 2000 you were requested to attend a patient, at Palmer Community Hospital by Nurse S, **Found Proved**

ii. you initially refused to visit the patient despite receiving information that a visit was required, **Found Proved**

iii. you then agreed to visit the patient but did not do so, **Found Proved**

f. You failed to attend the supervision session arranged with Dr L on 10 October 2000, **Found Proved**

g. Whilst on duty on 23 November 2000 you,

i. absented yourself from the hospital without leave, **Found Proved**

ii. failed to respond to your pager on two occasions, **Found Not Proved**

h. You failed to attend a Community Mental Health Team meeting on 23 November 2000 without prior explanation, **Found Proved**

i. You failed to attend a meeting with Mr R on 5 January 2001 without justification or explanation, **Found Not Proved**

j. In September 2000 you gave a patient under psychiatric care the telephone number of a dating agency, **Found Proved**

k. Your conduct as described in heads 2b to 2j above was,

i. inappropriate, **Found Proved**

ii. unprofessional; **Found Proved**

'3. a. Between 20 June 2001 and 20 July 2001 you were employed at Pontefract General Infirmary as a Locum Senior House Officer, **Found Proved**

b. When Dr W, the CSU Director, arranged to see you with Mr L, the General Manager, on 18 July 2001 concerning complaints made against you by ward sisters and other nursing staff,

i. you said you would not speak to Dr W and Mr L, **Found Not Proved**

ii. you described a colleague as a stupid cow, **Found Proved**

iii. you accused other colleagues of being rude and of being liars, **Found Not Proved**

c. You spent excessive periods of time using the computer on Ward 7, **Found Not Proved**

d. In discussion with Sister H of Ward 7, you referred to a hospital phlebotomist as a liar, **Found Proved**

e. i. on 19 July 2001 you failed to respond to three requests from Nurse C to attend a patient and write up a prescription, **Found Proved**

ii. you subsequently gesticulated rudely at her, **Found Not Proved**

iii. you then told her you had written the prescription earlier that day, **Found Not Proved**

iv. your failure to inform the nursing staff immediately after you had written the prescription led to the patient being without medication unnecessarily, **Found Proved**

f. i. on or about 19 July 2001 you were requested by Nurse W to complete a form to authorise tests on a patient, **Found Proved**

ii. you ignored her requests, **Found Not Proved**

iii. you behaved in a dismissive manner towards her, **Found Not Proved**

g. .....

h. Your conduct as described in heads 3bii, 3d, 3ei, 3eiv above was,

i. inappropriate, **Found Proved**

ii. unprofessional; **Found Proved**

"And that in relation to the facts alleged you have been guilty of serious professional misconduct." **Guilty Of Serious Professional Misconduct**

DETERMINATION

"Mr Braslavsky:

The Committee have carefully considered the evidence they have heard in this case. Dr Obi was not present and was not represented but despite this the Committee have been conscious both in the questions they have asked and their evaluation of the evidence of their need to ensure a fair hearing. Our reasons for deciding to hear the case in Dr Obi's absence are set out in the document attached to this determination.

On or about 1 to 3 April 2000 Dr Obi was employed by Harrogate Health Care Trust as a Locum Senior House Officer. On 2 April 2000 a patient was admitted to the Coronary Care Unit with an acute myocardial infarction. Dr Obi failed to prescribe analgesia for the patient further to that provided by the Accident and Emergency Department. Dr Obi failed to initiate thrombolysis although this was clinically indicated and he failed to seek advice from senior colleagues when it was appropriate and necessary for him to do so. The Committee found his conduct to be inappropriate, unprofessional and to have put a patient at risk. The Committee found proved that Dr Obi failed to attend and conduct an out-patient clinic for Dr D on 3 April 2000 without adequate notice or explanation.

Between August 2000 and December 2000 Dr Obi was employed by South Tyneside Healthcare Trust as a Senior House Officer. On 20 October 2000 Mr P brought his wife to the Accident and Emergency Department of South Tyneside District Hospital for treatment for an acute episode of a long term psychiatric disorder. Dr Obi said to him "We can't admit her for talking" and "If you can't stand it move out". The Committee found these comments to be insensitive and offensive.

On 25 October 2000, Dr Obi was requested to assess a patient who was considered to be at risk of self-harm. After Dr Obi had attended the patient, he wrote inappropriate notes about the duty medical team in his medical record. On 29 November 2000 Dr Obi responded to switchboard staff in an unhelpful and offensive manner on the telephone and at the hospital switchboard. On 6 October 2000 Dr Obi was requested to attend a patient, at Palmer Community Hospital by Nurse S. Dr Obi initially refused to visit the patient despite receiving information that a visit was required. He then agreed to visit the patient but did not do so.

Dr Obi failed to attend the supervision session arranged with Dr L on 10 October 2000. Whilst on duty on 23 November 2000 he absented himself from the hospital without leave. Dr Obi failed to attend a Community Mental Health Team

meeting on 23 November 2000 without prior explanation. In September 2000 Dr Obi gave a patient under psychiatric care the telephone number of a dating agency.

The Committee found Dr Obi's conduct as described in the above three paragraphs to be inappropriate and unprofessional.

Between 20 June 2001 and 20 July 2001 Dr Obi was employed at Pontefract General Infirmary as a Locum Senior House Officer. When Dr W, the CSU Director, arranged to see him with Mr L, the General Manager, on 18 July 2001 concerning complaints made against him by ward sisters and other nursing staff, Dr Obi described a colleague as a "stupid cow".

In discussion with Sister H of Ward 7, Dr Obi referred to a hospital phlebotomist as a liar. On 19 July 2001 he failed to respond to three requests from Nurse C to attend a patient and write up a prescription. Dr Obi's failure to inform the nursing staff immediately after he had written the prescription led to the patient being without medication unnecessarily. Again the Committee found Dr Obi's conduct to be inappropriate and unprofessional.

Dr Obi has contravened a number of principles contained in Good Medical Practice (both July 1998 and May 2001). With regards to good clinical care, this must include an adequate assessment of the patient's condition, based on the history and clinical signs, and if necessary, an appropriate examination. It must also include taking suitable and prompt action when necessary. On a number of occasions he failed to attend to patients. Also in providing care, Good Medical Practice states that you must recognise and work within the limits of your professional competence, be willing to consult colleagues and you must be competent when making diagnosis and when giving or arranging treatment. This was not evident in the incident at Harrogate.

With regards to maintaining performance, Good Medical Practice states that you must work with colleagues to monitor and maintain the quality of the care you provide and maintain a high awareness of patient safety. With regards to working with colleagues you must always treat your colleagues fairly and not make unnecessary or unsustainable comments about them. The Committee have found proved that Dr Obi has made rude and inappropriate comments to patients and to his colleagues. The pattern of behaviour displayed by Dr Obi has in some instances had a direct detrimental effect on patients. However, of equal concern was the indirect risk to patients by his failure to respond appropriately to other staff.

Accordingly, the Committee find Dr Obi guilty of serious professional misconduct.

Dr Obi is neither present today nor represented. The Committee have not received any testimonials or other mitigation on his behalf.

In deciding whether to take action in relation to Dr Obi's registration, the Committee have carefully considered the issue of proportionality and concluded that the reputation of the medical profession is more important than the fortunes of any individual member. It is the duty of this Committee to protect patients and maintain

public confidence in the medical profession. It is also our duty to ensure that the public continues to have confidence in self-regulation of the medical profession.

We did not think it necessary to postpone the case for further information.

The Committee have carefully considered each of the sanctions provided for in the Medical Act 1983. A reprimand is clearly inadequate in the circumstances of this case.

The Committee then considered carefully, whether to impose conditions on his registration which would need to be proportionate, enforceable and measurable. We have concluded no such conditions would be appropriate. We found no evidence that Dr Obi would comply or even recognise the need to do so.

The nature of the findings against Dr Obi are serious and the Committee have concluded that it is not appropriate to allow him to continue in medical practice at this time. The Committee have therefore directed the Registrar to suspend his registration for a period of 12 months or when his limited registration expires whichever is the sooner.

The effect of the foregoing direction is that, unless he exercises his right of appeal, his registration will be suspended for a period of 12 months or when his limited registration expires whichever is the sooner beginning 28 days from the date this notice is deemed to have been served upon him.

Having concluded that Dr Obi's registration should be suspended, the Committee will now go on to determine whether they consider it necessary for the protection of the members of the public or in the doctor's own interests to impose an order for the immediate suspension of his registration. Before deciding whether it is necessary to do so, the Committee invites submissions on this point from Mr Braslavsky.

DETERMINATION ON IMMEDIATE SUSPENSION
"Mr Braslavsky:

Given the serious nature of the findings against Dr Obi and the potential risk to patients the Committee have concluded that it is necessary for the protection of members of the public that his registration be suspended with immediate effect.

The effect of the foregoing order and the direction for suspension previously announced is that Dr Obi's registration will be suspended from the date that this letter is deemed to have been served upon him and on that date the Interim Order imposed upon him will be revoked.

That concludes this case".

..... .....
Signed Date