BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(23)14

AND

RISHI PATEL (01-20021)

DETERMINATION OF A SUBSTANTIVE HEARING
13 - 21 NOVEMBER 2023

Committee Members:	Mr James Kellock (Chair) Mr Paul Curtis (Lay) Ms Diane Roskilly (Lay) Ms Gemma O'Rourke (Optometrist) Dr Ewen MacMillan (Optometrist)
Clinical adviser:	N/A
Legal adviser:	Ms Jennifer Ferrario
GOC Presenting Officer:	Ms Rachel Birks, Solicitor
Registrant present/represented:	Yes and represented by Counsel
Registrant representative:	Mr Scott Ivill, Counsel
Hearings Officer:	Mr Terence Yates
Facts found proved:	1a, 1b, 1c 2a, 2b
Facts not found proved:	N/A
Misconduct:	Yes
Impairment:	Yes
Sanction:	3 month suspension (no review)
Immediate order:	No immediate order

ALLEGATION

1. *On or around 18 January 2021 you accessed Patient A's electronic records for the appointment on 30 May 2019 and amended them by adding the words;*

   a. "lid irritation and flaking in the mornings"; and/or

   b. "OCT normal"; and/or

   c. "advised to come back or see GP if lid hygiene and hot compress doesn't [sic] resolve it

2. *Your actions set out at 1 were:*

   a. Dishonest; and/or

   b. Misleading

And by virtue of the facts set out above, your fitness to practise is impaired by reason of misconduct

DETERMINATION

Admissions in relation to the particulars of the allegation

1. The Registrant admitted particulars 1a - c and 2b of the allegation on a specific basis.

Background to the allegations

2. The Registrant has been a registered Optometrist with the General Optical Council ('the Council') since 27 January 2003. He has worked for Specsavers since 2001 and in 2005 became an Optometrist Director at the [redacted] store, [redacted].

3. On 30 May 2019, Patient A attended an appointment at Specsavers in [redacted]. The Registrant carried out an eye examination and made some contemporaneous notes.

4. At the time of the examination in the Patient A's record, the Registrant recorded the reason for the visit as,

   'LST 3yrs ago boots worthing DV worse s and now ove the last year dv worse c, TV blurred varifocal wearer NV worse c, now betrter s No headaches No diplopia No other problem reported.'

5. In the section 'Additional tests' the Registrant wrote 'OCT.'

6. In the section ‘Advice given/Action taken’ the Registrant recorded the following,

   ‘new rx improves DV. see disp notes. px advised to remove specs for prolonged reading. mild mgd and blepharitis, recommend hot compress and lid wipes. use artificial tear spray more regularly’

7. On 14 January 2021, Patient A submitted a complaint in writing to Specsavers by email, in which he wrote that when he had attended for an eye test on 30 May 2019, he had asked the Registrant during the consultation about a small lump on his right bottom eyelid which had been present for several weeks and the Registrant had told him that it was a cyst. According to Patient A, the Registrant had told him to put a hot compress on the lump twice daily for at least two weeks and to use the lid spray regularly. Patient A attached the GOS2 prescription form that the Registrant had completed at the time. On 6 December 2020 Patient A had had a biopsy in relation to the lump and it was diagnosed as a tumour resulting in surgery.

8. The Registrant was informed of the complaint and on the 18 January 2021, he accessed Patient A’s electronic records and amended the record for the appointment on 30 May 2019 as follows,

   (a) Under the ‘Reason for visit’ section he added the words *‘lid irritation and flaking in mornings.’*

   (b) Under the ‘Additional tests’ section he added the word *‘normal’* after *‘OCT.’*

   (c) Under the ‘Advice given/Action taken’ section he added the words *‘advised to come back or see GP if the lid hygiene and hot compress doest [sic] resolve it.’*

   (d) He removed the words *‘px advised to’* and ‘*use.’*

9. A subsequent audit trail of Patient A’s records illustrated that the records had been amended on 18 January 2021.

10. On the 23 February 2021, Patient A referred the matter to the General Optical Council (‘the Council’). The Registrant, in a letter from his Solicitor to the Council on 7 September 2022, admitted to making the amendments to Patient A’s records.

Preliminary issue

Basis of admission

11. Before the allegations were read out, the Committee asked the Council’s legal representative, Ms Birks to clarify the Council’s position in terms of what is alleged in terms of allegation 2b and ‘misleading.’ Ms Birks said that there are two limbs to the Council’s case. First that none of the amendments made on the 18 January 2021 were marked as non-contemporaneous and second, that the Registrant had no actual recollection of carrying out any of the amendment content but tried to create

the impression that it had been included in the original notes. She added that Patient A maintains that they did not take place. In summary she said that the misleading conduct relates to deliberately including content that he knew was not contemporaneous but wanted it to appear as though it was and that the content was not an accurate description of that which had taken place.

12. Mr Ivill responded and told the Committee that whilst the amendments at allegation 1a – c would be admitted, the basis for the admissions was that it was not a deliberate act to mislead but that it was objectively misleading because the amendments gave the appearance of having been created contemporaneously. He said that the second limb of the Council's position is disputed because the information added was reflective of that which would have taken place and was therefore accurate.

Admissions

13. The Registrant admitted Particulars 1a - 1c.

14. The Registrant admitted Particular 2b. Mr Ivill told the Committee that the basis of the admission was that the Registrant admitted that by omitting to make a note in the records that the amendments on 18 January 2021 had been added retrospectively, a person reading the notes would have been misled into understanding that the amended content had been included at the same time as the original notes.

Evidence and submissions in relation to the facts

15. The Committee carefully considered the Council's bundle which consisted of 267 pages and a bundle provided by the Registrant consisting of 72 pages. The Council's bundle included but was not limited to a witness statement from Patient A, Specsavers records for Patient A, and an expert report and addendum report from Optometrist Dr Anna Kwartz ('Dr Kwartz'). The Registrant's bundle contained a witness statement from the Registrant dated 16 October 2023 and an expert report from Optometrist Mr Richard Booth, ('Mr Booth'). There was a further bundle from the Registrant containing testimonials from ten of his colleagues.

16. The Council called Dr Kwartz to give expert witness evidence for the Council. The Registrant gave oral testimony followed by Mr Booth, the Registrant's expert witness.

17. Ms Birks made closing submissions on behalf of the Council. She said that it was for the Council to prove their case on a balance of probability and invited the Committee to find the evidence of Dr Kwartz reliable and reminded the Council that Patient A's witness statement had been admitted as hearsay evidence at an earlier hearing. For Particulars 1a - 1c she said that the evidence indicated that the content was inaccurate as it was not supported by contemporaneous evidence, the Registrant had no recollection of the consultation including reviewing the OCT scan, and the entries had been inserted twenty months after the appointment. Ms Birks said that according to the Registrant he knew that he should have annotated the entries as retrospective but did not do so. She said that the Council's position is that the amendments were deliberately misleading because they appeared to be

contemporaneous when they were not, and the content was not accurate, all of which was known to the Registrant at the time. In making her submissions on dishonesty Ms Birks said that the evidence illustrates that the Registrant panicked when he was informed of the complaint; he knew that Patient A's records would be reviewed; he altered the records to provide a more supportive account of the consultation which is what he achieved; despite it being his usual practice he did not mark the amendments as retrospective; the content at 1a was added into the middle of a sentence; Mr Booth accepted that the alterations could hinder an internal investigation and the Registrant acknowledged making the amendments only after it had been recognised by an audit trail. Ms Birks said that in applying the case of ***Ivey***, an ordinary, decent and well-informed person, would find the conduct at 1a – c deliberately misleading and/or dishonest.

18. Mr Ivill made closing submissions on behalf of the Registrant. He said that it is for the Council to prove their case and the specific allegations. He invited the Committee to consider whether in the circumstances it was inherently improbable that the conduct involved an intention to mislead or act dishonestly. Mr Ivill said that the Committee should consider the fact that the Registrant admitted Particulars 1a – c and 2b at the outset of the proceedings and invited the Committee to consider this alongside the testimonials which refer to the Registrant as a person that is honest and truthful. He said that the testimonials are from people that know the Registrant well and the content should assist the Committee in supporting the Registrant's credibility and in assessing whether he had a propensity to act dishonestly.

19. Mr Ivill submitted that the evidence of Patient A should be treated with caution as it is untested. He said that Patient A's evidence in relation to the disputed facts are not supported by the contemporaneous evidence and highlighted that Patient A had stated that the Registrant took no notes during the consultation which is inaccurate.

20. In relation to allegation 2a, Mr Ivill said that he agreed that the correct test for the Committee to apply was ***Ivey***. He said that the Council's position is that as the Registrant cannot recall the consultation, that the content at Particulars 1a – c is inaccurate, and this is not accepted. He highlighted that in relation to 1a, this is supported by the GOS2 document; the amendment at 1b was in line with the OCT result; the amendment at 1c was part of routine advice that he provided to symptomatic patients and there was reference to applying a hot compress in the contemporaneous material. Mr Ivill submitted that it was for the Council to prove on a balance of probability that the amendments were inaccurate, and deliberately inaccurate. He said that the Registrant's position is that where information is not recorded does not necessarily mean that it was not said. Mr Ivill said that if the Registrant had set out to intentionally mislead a person reading the record or had acted in a dishonest manner, a reference to the small lump on Patient A's eyelid, would have been a prime candidate for an amendment because it was a key feature of the complaint from Patient A. In the absence of writing any untrue content, Mr Ivill invited the Committee to find that the amendments at 1a – c had been misleading on the basis only admitted, namely that the amendments had not been annotated as having been made retrospectively and this amounted to objectively misleading.

Legal Advice

21. The Committee accepted the advice of the Legal Adviser. The Legal Adviser reminded the Committee that the burden of proof lies with the Council in respect of the facts, and that the standard of proof is the balance of probabilities pursuant to Rules 39 and 38 respectively of The General Optical Council (Fitness to Practise) Rules 2013. The Committee was advised to consider each of the particulars of the allegation separately and to consider all the evidence. The Legal Adviser advised the Committee that whilst the evidence of Patient A had been admitted by a previous Committee as hearsay evidence, that it is a matter for this Committee to exercise its own independent judgement having heard all the evidence as to what weight if any to attach to it. The Committee were invited to include in their written decision how much weight if any had been attached to Patient A's witness statement.

22. The Legal Adviser reminded the Committee that Particulars 1a – 1c and 2b had been admitted on a specific basis, namely that any person reading the record of the consultation on 30 May 2019 for Patient A would objectively have been misled into understanding that the amendments had been included in the original record because the amendments had not been annotated as retrospective. The Legal Adviser said that it is for the Committee to exercise its own independent judgement as to whether the amendments at Particulars 1a – 1c had been misleading for any other reason. In relation to Particular 2b, the Legal Adviser advised the Committee to consider whether the conduct admitted was misleading and if so whether it was deliberately misleading and referred the Committee to the case of *Raychaudhuri v GMC & PSA [2018] EWCA Civ 2027*.

23. In relation to Particular 2a, the Legal Adviser informed the Committee of the test for dishonesty as laid out in the case of *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 76* and in applying the relevant test, invited the Committee to consider the context of the alleged dishonesty, the act of amending the content and the conduct of the Registrant thereafter. The Legal Adviser invited the Committee to consider the previous good character of the Registrant particularly as the issues to be determined involved dishonesty in line with *Khan v GMC [2021] & Sawati v GMC [2022]* and advised the Committee that it could consider testimonials in assessing a propensity to be dishonest.

24. The Committee was further advised to consider the credibility of the expert witnesses, by assessing their oral and written evidence and if it preferred one expert's evidence over the other to say so in the written determination together with its reasons.

The Committee's considerations and decisions

25. The Committee considered each particular of the allegations in turn, which involved assessing the evidence including the documentary and oral testimony. The Committee found the evidence of Dr Kwartz to be credible and reliable. A summary of her evidence is as follows:

26. Dr Kwartz, an Optometrist and member of the Council's panel of experts, confirmed that she had produced two reports for the Council dated 10 March 2022 and 25 March 2023 and a joint report with Mr Booth, the Registrant's expert witness dated 8 November 2023. During her evidence Dr Kwartz was asked about the content of the amendments made by the Registrant and referred to the document produced by Patient A entitled 'GOS2 Patient's optical prescription or statement.' In relation to Particular 1a, Dr Kwartz told the Committee that as there was mention in the GOS2 document of *'flaking on lashes'* that this had been included in contemporaneous documentation. Dr Kwartz also said that the reference to flaking on the GOS2 document does not necessarily reflect any mention of it by the patient, because she said that sometimes a patient would be unaware, and the flaking may only be seen by the Optometrist during an examination. Dr Kwartz said that by adding the words at Particular 1a, no risk of significant harm had been caused to the patient.

27. When asked about Particular 1b, Dr Kwartz said that the amendment by the Registrant reflected an accurate description of the OCT examination. She said that the notes suggested that the Registrant reviewed the OCT examination on the 30 May 2019 but in reality, she does not know when it was reviewed because the entry was inserted twenty months after the consultation. Dr Kwartz said that by adding the words at Particular 1b, no risk of significant harm had been caused to the patient.

28. In relation to Particular 1c, Dr Kwartz told the Committee that if it was the Registrant's practice to always give this advice to patients with symptoms when they were not being referred to a medical practitioner, that this was sensible advice. She said that the issue for her was whether the advice had actually been given because it had been added twenty months after the consultation and had not been part of the contemporaneous documentation. Dr Kwartz accepted when asked by Mr Ivill that just because something is not recorded does not mean that it was not said. She also said that including this advice in the records did not pose a risk of significant harm to the patient having regard to the nature of his symptoms.

29. In terms of the Registrant's conduct, Dr Kwartz told the Committee that she maintained the opinion that she had included in her expert reports, namely there had been a significant departure from the professional standards expected of the Registrant because the amendments having been made 20 months after the examination had not been marked as retrospective. She told the Committee that it had been appropriate to Stage 2 Core Competencies General Optical Council 2011when considering the relevant professional standards and that whilst she accepted that Mr Booth, the Registrant's instructed expert was an experienced expert witness, that she stood by her report in which she had found that the conduct had fallen far below the standard expected.

30. The Registrant gave oral evidence. The Committee did not find his evidence to be entirely credible. The Committee accepted his evidence when he said that he had not met Patient A prior to the eye examination on 30 May 2019; that he would have compiled the patient's notes during the examination by using a computer and that some words were pre-populated which made the note taking process easier; that he

had no recollection of the examination of Patient A and was reliant upon the documentary evidence in the bundle.

31. When the Registrant was asked about the amendments, he said that he was informed of the complaint from Patient A whilst he was off work [redacted] and when he returned, he panicked because he had never had a complaint made against him before and at the time, he regarded it as a serious matter. He accessed Patient A's electronic records on 18 January 2021 and decided to add the words at Particulars 1a, b and c. When asked if he had amended a patient's record retrospectively before this date, he said that he had. He said that he had amended records regularly upon receiving new information but on those occasions, he would have dated the amended text and placed his initials next to it. He said that prior to January 2021 he had not put later text in inverted commas, but that since this matter arose, he has begun to do so. He told the Committee that on 18 January 2021 when he made the amendments that he had been aware that he should have indicated that they had been added retrospectively but at the time because he had been panicking, he forgot, which he said had been foolish and he regretted it.

32. In relation to 1a, the Registrant told the Committee that inserting the words into the 'Reason for the visit' section of Patient A's record was inaccurate because he had not annotated it as retrospective. He added that there had been no contemporaneous documentation in support of this addition. He accepted that the inaccuracy was misleading for a person reading the record and he could not be sure that that had been the reason for the visit.

33. In relation to 1b, the Registrant told the Committee that he did not recall checking the OCT examination or discussing it with the Registrant but said that it had been his usual practice and that was why he had added the words to the relevant section. He said that he had written the word 'OCT' but had omitted to record that the result had been normal and at the time of the amendment had been over 90% certain that he would have discussed it with Patient A. He accepted that having omitted to reflect in the notes that the amendment had been made retrospectively was misleading for any person reading the notes and that for this reason the text was inaccurate and misleading.

34. When he was asked about 1c, the Registrant said that he had no recollection of having given the advice but told the Committee that he always advised this type of safety net advice to patients that presented with symptoms that did not warrant onward referral. He said that he always said it, to cover himself. He accepted that it was misleading because the insertion of this text did not include any indication that it had been added retrospectively.

35. The Registrant told the Committee that a letter from his Solicitor dated 7 September 2022 in which it stated that he accepted *'that these amendments to the records were therefore deliberately misleading'* related to the fact that he had intentionally added the text retrospectively rather than it being an accident, and was deliberate in that sense. He said that he did not set out to deliberately mislead but had wanted to amend the record to produce an accurate reflection of the consultation that had taken

place. He told the Committee that the text that he had inserted was not related to the complaint raised by Patient A regarding the small lump on his eye lid. He maintained that the retrospective amendments were an accurate reflection of the consultation and in making the amendments he had relied upon the GOS2 document. He had agreed that he had wanted to present a more supportive account of the consultation from his perspective.

36. In answer to questions from the Committee, the Registrant said that whilst he would always give safety net advice to patients such as Patient A and would usually write the advice given in the record, that on the 30 May 2019 he had forgotten to include it in the patient's notes. He told the Committee that he added the text at 1c retrospectively because he reviewed the GOS2 document and thought that he should have included it. In relation to 1a he accepted that he had not written it in the section about the reason for the visit at the time and had recorded that no other problems had been reported by the patient. The Registrant said that he did not know why some of the amendments had been placed in the middle of original text rather than at the end of the sentence and added that he could not recall what was in his mind at the time. When he was asked about Patient A's evidence that he told the Registrant about a cyst and the records do not mention this. The Registrant said that the treatment on the GOS2 form was for the cyst, then he said that he was not sure because sometimes the treatment for a cyst could be the same as for Blepharitis and MGD and then he said that it was for the MGD.

37. When the Registrant was asked whether he had discussed the retrospective amendments with his business partner Mr A prior to Mr A replying to Patient A's complaint, he said that he had not. The Committee referred the Registrant to his witness statement where he said that he had made the retrospective amendments to provide a more supportive record of the consultation. When he was asked for whom would the amendments be more supportive, the Registrant said that he was unsure, and he accepted that the only person likely to read them at that time would have been Mr A.

38. Richard Booth, an expert instructed by the Registrant gave oral evidence. The Committee did not consider his evidence to be credible in its entirety. He confirmed that he had produced a report dated 13 October 2023 and a joint report with Dr Kwartz dated 8 November 2023. He told the Committee that in his reports he had described the Registrant's conduct in adding the text retrospectively at Particulars 1a -1c as misleading because there had been no annotation of the later date. He said that he maintained that position and did not believe that the Registrant had set out to deliberately mislead anyone.

39. Mr Booth said that the amendment at allegation 1a had been accurate because the Registrant had relied upon the GOS2 form and that 1b was accurate because it reflected the OCT result. He was asked about the comment in his report of the 13 October 2023 when he said that as the amendments at 1a and 1b were accurate, it was more likely than not that the amendment at 1c was accurate too and he said that he stood by that opinion *'but I may be totally wrong.'* When Mr Booth was asked by the Committee for his opinion about the placing of the material at 1a in the middle of

a sentence, Mr Booth said that in his view it was entirely proper to place it within the sentence as it had been amongst other symptoms. Mr Booth said that he cannot say with any certainty whether the Registrant provided the safety netting advice to Patient A in relation to Particular 1c and he accepted that there was no contemporaneous evidence to indicate that he had.

40. In relation to the accuracy of the content of the amendments, Mr Booth said that as the Registrant cannot recall the consultation with Patient A, that the information at 1a and 1c cannot be accurate but looking at the information recorded as a whole, *'it probably was but that is my judgement.'* Mr Booth told the Committee that in his opinion the information at 1b was accurate because the Registrant had said that he had reviewed the OCT result on the 30 May 2019 but had not recorded this and there was no evidence to suggest otherwise, and the letters 'OCT' appeared in the original record. He said that in his opinion the Registrant had probably forgotten to record on the 30 May 2019 that he had reviewed the OCT on this date.

41. When he was asked in cross examination about the retrospective amendments following the complaint from Patient A and the investigation by Specsavers, Mr Booth said that the information that had been inserted fell in the middle of the scale in terms of assisting or hindering the investigation and leaned towards assisting. During questions from the Committee Mr Booth said that the amendment at 1c would more likely than not, hinder the investigation. Mr Booth said that in his opinion the conduct admitted by the Registrant fell below the professional standards expected but not far below because the content of the amendments did not add significantly to the clinical information and *'was not leading someone up the garden path.'*

Allegation 1

On or around 18 January 2021 you accessed Patient A's electronic records for the appointment on 30 May 2019 and amended them by adding the words;

a. "lid irritation and flaking in the mornings"; and/or

b. "OCT normal"; and/or

c. "advised to come back or see GP if lid hygiene and hot compress doesn't [sic] resolve it

Proved

42. The Committee found 1a, 1b and 1c proved by admission.

43. The Committee considered the documentary evidence and the evidence of the Registrant very carefully. The Committee noted the audit trail and the Registrant's own evidence, in that he had admitted accessing and amending Patient A's electronic records on or around 18 January 2021 with the content at particulars a – c of the allegation. The Committee found that there was no reason to doubt the audit trial or the Registrant's account.

Allegation 2

Your actions set out at 1 were:

a. Dishonest; and/or

b. Misleading.

Proved

44. The Committee found 2a and 2b proved.

45. The Committee considered Particular 2b first before moving to consider 2a. It noted that the Registrant accepted having acted in a misleading manner but that this was limited to the following basis as clarified by Mr Ivill at the beginning of the hearing:

'The Registrant accepts that it was objectively misleading to not include an annotation of the date in the records when the amendments were made because this gave an appearance to any person reading the patient record that the amendments had formed part of the contemporaneous notes which they did not. The basis does not include a deliberate act to mislead.'

46. The Committee considered the Council's position and reminded itself that the Council had brought its case on the premise that the conduct had been deliberately misleading because the amendments had not been marked as non-contemporaneous and the content of the amendments had been inaccurate. The Council's case was that set against the backdrop of the complaint from Patient A, the panic accepted by the Registrant and the Registrant's explanation that he had wanted to create a more supportive account of the consultation when he could not recall it, that this was evidence of an intent to mislead.

47. The Committee reminded itself of the factual circumstances leading up to the amendments by the Registrant to Patient A's notes. It found the following:

a. The Registrant altered the record only after having been informed of the complaint from Patient A.

b. It is accepted by the Registrant that when he was informed of the complaint, he considered it to be serious.

c. Mr Booth had told the Committee, that the original notes in Patient A's record had appeared to be accurate. Mr Booth said that often practitioners would insert the word 'OCT' to indicate that the scan had been discussed with the patient and that there was no abnormality. The Committee found on the basis of Mr Booth's evidence that there had been no need to make any amendments.

d. The Registrant said during the hearing that it was his usual practice to sign and date retrospective amendments but on this occasion he had forgotten. The Committee found that to be unlikely in view of the complaint that had been received and having heard from the Registrant that it was his standard practice ordinarily.

e. In relation to 1a, the Committee considered each term, namely *'lid irritation,' 'flaking,'* and *'in the mornings'* individually and found that the Registrant had taken the word *'flaking'* from the GOS2 document. The Committee took the view that to place these words in the 'Reason for Visit' section was inaccurate because there was no evidence to indicate that Patient A had raised these symptoms as the reason for the appointment. The Committee did not rely on the witness evidence of Patient A in arriving at its decision but on the absence of any contemporaneous documentation. The Committee accepted the evidence of Dr Kwartz when she said that just because it is written in the GOS2 document that the patient was experiencing flaking does not automatically mean that the patient had raised it because the patient may have been unaware of this sign. The Committee also accepted Dr Kwartz's evidence that flakiness would not necessarily be worse in the morning. The Committee considered the GOS2 document and found that the treatment prescribed would have related to the diagnosed conditions of Blepharitis and MGD and could possibly have included flakiness as the treatments would have worked in conjunction with each other. In terms of the reason for the visit the Committee determined that as the Registrant could not recall the consultation when making the amendments; the reference in the relevant section of the original record to there being no other reason for the visit, the placing of the retrospective text in the middle of a sentence and in the absence of any contemporaneous documentation, that it was more likely than not that the Registrant added the content to improve the patient record in light of the complaint without knowing whether it had actually been a reason for the visit.

f. In relation to 1b, the Committee found that to insert the word 'normal' was accurate in the sense that the OCT scan had produced a normal result. The Committee went on to find that when he made the amendment, the Registrant could not recall whether he had carried out a review of the scan on the 30 May 2019 and it was therefore inaccurate and misleading information as a reader would believe the Registrant had reviewed the scan on the 30 May 2019. By omitting to annotate it as retrospective, the Committee found that he had decided to insert this text to improve the record in light of the patient complaint.

g. In relation to 1c, the Committee reminded itself of the expert witness evidence from both Dr Kwartz and Mr Booth in that it would have been sensible to have provided the safety netting advice. The issue for the Committee was whether the Registrant intentionally sought to mislead that the advice had been provided at the consultation. The Committee noted that when the Registrant made the amendment, he could not recall whether he had provided the advice; there was no evidence to suggest that Patient A returned to Specsavers after the consultation, (in line with the amended reference to advice) and that despite the Registrant telling the Committee that it was his usual practice to record the advice at any similar consultation, he had not done so on this occasion. The Committee reminded itself of the Registrant's oral evidence on this issue and found that he had appeared confused about the use of the word *'it'* at allegation 1c. The Committee determined that to include the specific text without retrospective

annotation was inaccurate and deliberately misleading and was done to improve the patient record in light of the complaint.

48. The Committee reminded itself of the factual circumstances after the amendments made by the Registrant to Patient A's notes. It found the following:

    a. The Registrant's evidence is that he panicked when he was informed of the complaint from Patient A, made the amendments and did not discuss having made them with his business partner. The Committee found that to be in a state of panic was understandable. The Committee reminded itself that the Registrant held the role of Director in Specsavers at the material time and had been in practice for several years. He would have been familiar with the requirements to keep accurate and contemporaneous records, be transparent and open and to lead by example. In relation to not discussing it with his business partner the Committee found that this was indicative of a person that was attempting to conceal the amendments.

    b. The Committee found that the Registrant did not inform anyone that he had made the amendments until the audit trail was brought to his attention following the report from Dr Kwartz of 10 March 2022. It noted that in Mr A's reply letter to Patient A dated 1 February 2021, Mr A made reference to the amended text at 1a and 1c. The Committee determined that when the Registrant made the amendments, he was unaware that an audit trail could be accessed or had forgotten that it could.

    c. The letter from the Registrant's Solicitor dated 7 September 2022 includes an admission that the Registrant acted in a deliberately misleading manner. The Committee has considered the explanation for this provided by the Registrant and accepts that at the time the letter was prepared, the Registrant had not admitted to deliberately misleading. The Committee has not attached any weight to this letter in terms of assessing whether the Registrant had intentionally set out to mislead.

    d. The Committee determined that the content at 1a – 1c, whilst not directly linked to the complaint from Patient A regarding a small lump on his eyelid, was information that would have potentially assisted the Registrant in any internal or Council investigation and he was aware of this when he made the amendments. The Committee placed particular weight on his silence in having made the amendments, until after he had been presented with the audit trail.

49. Having determined the factual circumstances, the Committee went on to find that on a balance of probability, the Registrant had acted in a deliberately misleading manner. Firstly he had intentionally omitted to annotate the retrospective amendments and second by inserting the new words in the middle of the text he had intended to mislead a reader of the record in believing that it had been made both contemporaneously, and was an accurate and comprehensive record of the consultation on the 30 May 2019.

50. The Committee considered Particular 2a.

51. The Committee had regard to the two-stage test laid out in *Ivey v Genting Casinos (UK) Ltd t/a Crockfords [2017] UKSC 76.* The Committee determined that its factual findings for Particular 2b were relevant to the first stage of the *Ivey* test in their entirety and took them into account when considering 2a.

52. Having regard to the Committee's factual findings the Committee determined that the Registrant knew in his mind that his actions in amending the record on or around 18 January 2021, as he did without annotation noting they were retrospective was wrong. Further the Committee took into account that he did not tell anyone at work about it. In addition, the Committee had not been satisfied by the Registrant's explanation that he had forgotten to annotate the records as he had said in evidence that this was his usual practice. The Committee found that if there was ever a time to carry out his usual practice it was when he had been facing a potentially serious complaint. The Committee took the view that whilst the Registrant may have panicked, he was able to refer to the GOS2 document, he had decided to insert some of the amendments in the middle of a sentence, and the safety netting advice insertion had used specific words. The Committee found that this was not consistent with being in a state of panic such that the Registrant had forgotten to carry out his usual practice. Further, the Committee also found that the Registrant knew in his mind that amending the record as he did without recollecting the patient, the consultation and the information at 1a - 1c was wrong.

53. The Committee had considered the expert evidence and assessed how it assisted if at all with the test for dishonesty. The Committee reminded itself of the evidence from Mr Booth and recalled that he had said that he had not been concerned about the amendments because in his opinion they were not relevant to the patient complaint or clinical outcome. He told the Committee that he had not doubted the legitimacy of the amendments despite there being no retrospective annotation because in his words *'if [the Registrant] says it happened it happened.'* The Committee further noted that in his report dated 13 October 2023, Mr Booth gave an opinion that if the amendments at 1a and 1b were accurate, on a balance of probability, the text at 1c must also have been accurate. The Committee rejected this evidence and preferred the evidence of Dr Kwartz in terms of the accuracy of the content of the amendments because she had relied upon the contemporaneous documentation.

54. The Committee went on to consider the second limb of the dishonesty test in *Ivey*; would the Registrant's conduct be considered dishonest by the standards of ordinary decent people?

55. The Committee determined that for each Particular 1a to 1c, an ordinary, decent person would consider the Registrant's actions to be dishonest.

56. The Committee considered the testimonials provided on behalf of the Registrant carefully. The Committee found that whilst the testimonials stated that the Registrant is an honest person, the Committee determined that on this occasion he had acted dishonestly.

57. In reaching this finding the Committee placed particular reliance upon the fact that the Registrant had been in a very senior role at the time of making the amendments; he had omitted to include a retrospective annotation when faced with a serious complaint despite stating that this was his standard practice and he had not told anyone in work about the amendments until they were found as part of the Council's investigation.

Misconduct

58. Having found the facts alleged proved, the Committee next considered whether the facts found proved amounted to the statutory ground of misconduct.

59. The Committee heard submissions on behalf of the Council from Ms Birks. She said that as there is no burden or standard of proof for this stage of the hearing and that it is entirely a matter for the Committee's own judgement whether the conduct amounted to misconduct. Ms Birks submitted that the Council's position is that the conduct amounted to misconduct, and she said that the evidence of the experts ought to be less relevant in terms of the Committee's assessment. Ms Birks referred the Committee to her skeleton argument and submitted that whilst all three limbs of the Council's overarching objective are engaged, the Committee should focus on the second and third limb because this is not a case where there is evidence of patient harm.

60. Mr Ivill told the Committee that he did not intend to make any submissions on misconduct other than to say that the Registrant accepted given the Committee's findings that his conduct fell short of the professional standards expected and the Registrant understands that the conduct found proven is serious.

61. The Committee received and accepted advice from the Legal Adviser. This included advice that in the absence of a statutory definition of misconduct, the Committee should exercise its own judgement and consider paragraphs 15.5 – 15.9 of the Council's Hearings and Indicative Sanction Guidance. The Legal Adviser also invited the Committee to refer to the judgement in the case of ***Roylance v GMC [2000] 1 AC 311***:

'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 practitioner in the particular circumstances. The misconduct is qualified in two respects. First it is qualified by the word 'professional' which link the misconduct to the profession … Secondly, the misconduct is qualified by the word 'serious.' It is not any professional misconduct which will qualify. The professional misconduct must be serious.'

62. The Legal Adviser also referred the Committee to the case of ***Nandi v GMC [2004] EWHC 2317 (Admin)*** where the court referred to ***Roylance*** and described misconduct as:

'a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be 'serious' such that it would be regarded as 'deplorable' by fellow practitioners.'

The Committee's decision on Misconduct

63. The Committee reminded itself of the relevant paragraphs of the Council's Hearings and Indicative Sanctions Guidance. The Committee also reminded itself that the Registrant's conduct, as proved, involved him acting in a deliberately misleading and dishonest manner when he amended Patient A's record twenty months after the consultation and (a) did not annotate the amendments as retrospective and (b) included information that he could not recall because he could not recollect the consultation or the patient.

64. The Committee agreed that the standards identified by Ms Birks in her submissions and skeleton argument were engaged. They were the following Council's Standards of Practice 2016:

8.1: Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care.

16.1: Act with honesty and integrity to maintain public trust and confidence in your profession.

17.1: Ensure your conduct, whether or not connected to your professional practice, does not damage public confidence in you or your profession.

65. The Committee determined that each of these standards had been breached by the Registrant. The Committee found that the Registrant had not maintained clear records, and he had acted in a deliberately misleading and dishonest manner. In relation to damaging public confidence, the Committee considered the nature of the misconduct and determined that the factual circumstances that led the Committee to arrive at its decision in relation to dishonesty were equally applicable when assessing seriousness. Upon reminding itself of these circumstances together with the fact that the conduct occurred in relation to the Registrant's clinical practice, the Committee went on to find that the nature of the misconduct was sufficiently serious such that it fell far below the professional standards expected. Further, the Committee determined that a fellow practitioner, in light of the deliberately misleading and dishonest nature of the misconduct, would regard the Registrant's actions as deplorable.

66. The Committee consequently determined that the facts found proved amounted to misconduct.

Impairment

67. Having determined that the facts proved amounted to misconduct, the Committee took into account a further bundle from the Registrant comprising of a supplementary

witness statement and reflection statement from the Registrant, copies of certificates for Continuing Professional Development courses and an additional testimonial. The Committee heard submissions by both legal representatives on impairment.

68. Ms Birks on behalf of the Council referred the Committee to her skeleton argument and invited the Committee to refer to the case of ***CHRE v NMC and Grant***. She said that as there is no evidence of patient harm in this case the Council relies upon bringing the profession into disrepute, breaching a fundamental tenet of the profession and the dishonest nature of the conduct. She submitted that current impairment ought to be found on a personal level because the Registrant has shown insufficient insight and remediation to demonstrate that there is no risk of repetition. She said that the public interest element of ***Grant*** also required a finding of current impairment to promote and maintain public confidence and to send a clear message to the profession and the wider public that the misconduct found, would not be tolerated.

69. The Committee also heard submissions from Mr Ivill on behalf of the Registrant. He said that a finding of misconduct should not automatically lead to current impairment. He agreed with the content of the Council's skeleton argument in terms of the case law and reminded the Committee that the issue is whether the Registrant's fitness to practise is impaired today. Mr Ivill submitted that according to the case of ***Yusuf v GMC***, a person is capable of demonstrating insight where they have disputed the misconduct alleged. He told the Committee that the Registrant had accepted the findings of the Committee and in his additional witness statement and reflection statement had demonstrated true insight into the wrongdoing that had been found proven. In terms of remediation, he said that the Continuing Professional Development courses undertaken by the Registrant were focussed on relevant topics and there had been no repetition of the conduct since it occurred almost three years ago. Mr Ivill said that in view of the evidence provided by the Registrant including the testimonials, that the risk of repetition is low and he referred the Committee to ***Cohen v General Medical Council*** where it was held that a person can be dishonest on one occasion but that a finding of current impairment is not always appropriate. Mr Ivill said that a finding of current impairment is not required on the grounds of the public interest because the Registrant is of previous good character, he has shown insight, remediation, remorse and there is a low risk of repetition. He invited the Committee to find that having been taken through the fitness to practise process with a finding of misconduct, that ought to be sufficient to uphold and maintain public confidence in the profession.

70. The Committee accepted the advice of the Legal Adviser which included advice that as there is no statutory definition of impairment that whether the Registrant is currently impaired will be a matter for the Committee's own independent judgement and the onus is on the Registrant to demonstrate that his fitness to practise is not currently impaired.

71. The Legal Adviser advised that there is a range of case law to assist the Committee and it should also have regard to paragraphs 16.1 – 16.7 of the Hearings and Indicative Sanction Guidance. The Committee were reminded of the Council's

overarching objective and that when considering the criteria for impairment, it should decide whether the Registrant's fitness to practise is currently impaired on a personal or public interest level or both. The Legal Adviser summarised for the Committee's benefit the factors to be taken into consideration regarding impairment as set out in ***Cohen v General Medical Council [2008] EWHC 581 (Admin)***. The Committee was advised to consider the oral testimony from the Registrant and the documents provided by the Registrant to the Committee including the testimonials, against the criteria set out in ***Cohen*****.** The Committee was advised that it should not use the Registrant's decision to dispute the dishonesty allegation against him, as set out in ***Sawati v GMC [2022]***. Also summarised by the Legal Adviser was the approach formulated by Dame Janet Smith in her Fifth Report from the Shipman case, cited with approval in ***CHRE v NMC and Grant EWHC 927 (Admin)***, namely whether the Registrant:

a. *Has in the past acted and/or is liable in the future to act so as to put a patient at unwarranted risk of harm; and/or*
b. *Has in the past and/or is liable in the future to bring the 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 profession; and/or*
d. *Has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

The Committee's decision on Impairment

72. The Committee had regard to the relevant paragraphs of the Council's Hearings and Indicative Sanctions Guidance and bore in mind the Council's overarching objective and gave equal consideration to each of its limbs as set out below:

'To promote, protect and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the profession and to promote and maintain proper professional standards and conduct.'

73. The Committee first considered the questions endorsed in ***Grant*** and ***Cohen*** in relation to past and future behaviour and it concluded that it agreed with the advocates that this was not a case where patient harm or risk of harm was relevant. It then considered whether the Registrant had in the past and/or was liable to bring the profession into disrepute and decided that in acting in a deliberately misleading and dishonest manner, that this was conduct that had brought the profession into disrepute.

74. The Committee carefully considered the bundle of documents that it had received from the Registrant regarding impairment and found that the Registrant had demonstrated insight and remediated himself such that there was a very low risk of repetition. The Committee was impressed with the targeted courses that the Registrant had undertaken as they were relevant to the misconduct and were also impressed that he had instigated strategies in his personal practice to try and assist him and his colleagues in the workplace to avoid errors of judgement when facing stressful situations. The Committee noted that some of the testimonials from

colleagues also spoke of how the Registrant had been open and transparent about the proceedings and how he had been dedicated to bettering his team and organisation. The Committee also noted that the Registrant had expressed considerable remorse and had apologised for his conduct. Further, the Registrant had reflected on the impact his conduct would have on the profession, the public and Patient A. Having found a low risk of repetition the Committee went on to find that the Registrant was not liable in the future to bring the profession into disrepute.

75. The Committee then considered whether the Registrant had breached a fundamental tenet of the profession and having regard to the nature of the misconduct, found that he had. The Committee found that the risk of the Registrant repeating the breaches was very low. In relation to the final matter to be considered in line with ***Grant****,* the Committee found that the misconduct included dishonesty and therefore the final question was answered in the affirmative in relation to past behaviour. The Committee went on to find in light of the impairment evidence received from the Registrant, his unblemished career since 2003 and the fact that there had been no repetition since 18 January 2021, that the likelihood of repeating the dishonesty was very low.

76. The Committee considered that dishonest conduct is difficult but not impossible to remediate. It had found that the Registrant had demonstrated insight, and had produced evidence of targeted and cogent remediation such that the risk of repetition was very low. For these reasons the Committee determined that the Registrant's current fitness to practise on a personal level was not impaired.

77. The Committee then considered whether the Registrant's current fitness to practise was impaired on a public interest level. The Committee reminded itself of paragraph 16.4 of the Council's Hearings and Indicative Sanctions Guidance and the case of *Grant,* where it was stated that the question the Committee should ask itself was:

> *'Not only whether the registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case.'*

78. The Committee considered the nature of the misconduct particularly the act of deliberate misleading and dishonesty. It determined that in circumstances where a Registrant had amended a clinical record with material that he did not recall, to create a more positive record having been faced with a serious patient complaint, that public confidence in the profession would be undermined if a finding of impairment were not made. The Committee determined that the nature of the misconduct was sufficiently serious such that the wider public would consider it to be deplorable and an ordinary well-informed member of the public would expect a finding of impairment to maintain and promote public confidence in the profession and to demonstrate that proper professional standards were being upheld.

79. The Committee determined that having regard to the public interest considerations, the Registrant's fitness to practise is currently impaired by reason of his misconduct.

Sanction

80. The Committee heard oral submissions from Ms Birks during which she said that the sanction to impose was a matter for the Committee to determine and she referred the Committee to the Council's Hearings and Indicative Sanctions Guidance ('the Guidance'). She highlighted to the Committee the relevant paragraphs of the Guidance in terms of the purpose of sanctions; the imposition of an appropriate and proportionate sanction and the overriding objective, particularly the promoting and maintaining of public confidence in the profession, and promoting and maintaining proper professional standards. Ms Birks invited the Committee to consider mitigating and aggravating factors and to impose the least restrictive sanction that will achieve the relevant public interest considerations.

81. Ms Birks submitted that the Council's view on sanction is that a period of suspension should be imposed, and she said that any less restrictive sanction would not adequately reflect the seriousness of the case or meet the public interest considerations. She submitted that there were no exceptional circumstances to warrant no further action, a financial penalty was not appropriate because this was not a case involving financial motivation or benefit to the Registrant, and there were no workable conditions that could be formulated to address the dishonest conduct. Ms Birks referred the Committee to the relevant paragraphs in the Guidance in relation to erasure and said that consideration ought to be given by the Committee to paragraph 21.35 part f.

82. In terms of suspension as an appropriate and proportionate sanction, Ms Birks referred the Committee to paragraph 21.29 of the Guidance and said that parts a – d were relevant. She said that whilst the impact of a suspension may be punitive for the Registrant that in line with the case of ***Bolton v Law Society [1994]*** the reputation of the profession was more important than the fortunes of any individual member. Ms Birks said that where the Committee impose a suspension, they should consider ordering a review hearing where it required some reassurance, based on the public interest grounds found at the impairment stage, that the Registrant would be safe to resume unrestricted practice once the period of suspension had expired.

83. Mr Ivill made submissions on behalf of the Registrant and began by providing a list of mitigating factors. He said that the Committee had determined that there had been no harm caused to the patient; the Registrant had demonstrated insight and remorse and had apologised for his actions; he had reflected on the impact of his conduct for Patient A, the Registrant's colleagues and the wider public; he had provided evidence of impressive targeted and cogent remediation; he had instigated strategies for himself and colleagues in the workplace when faced with stressful situations; several positive testimonials had been provided and there had been a lapse of time of over two and a half years since the misconduct with no repeat behaviour.

84. Mr Ivill said that in addition to these findings the Committee should consider as mitigating factors that the dishonesty had occurred as a single episode; it could quite properly be described as out of character; the Registrant had been under considerable stress at the time of the dishonest conduct which had clouded his judgement; he had engaged with the process and had otherwise had an unblemished career.

85. Mr Ivill submitted that the least restrictive sanction should be imposed, in ascending order. He said that it would be unrealistic of him to submit to the Committee that to take no further action would be appropriate in the circumstances. He submitted that a financial penalty would be a sufficient and proportionate penalty because it would have a deterrent effect and would send out a signal to the profession and the wider public that the conduct was unbefitting behaviour. Mr Ivill said that the case is primarily concerned with maintaining public confidence and proper professional standards and that during the last two and a half years, the Registrant has demonstrated that he was able to practise safely. He submitted that the public interest would be best served by permitting the Registrant to continue to provide a quality service to his patients.

86. Mr Ivill told the Committee that if a financial penalty was not imposed that this would involve a leap to a suspension because conditions on the Registrant's registration would be inappropriate. He said that if a period of suspension was imposed, the Registrant's directorship agreement with Specsavers would be terminated because he would be in breach of the requirement that he be registered with the Council. Mr Ivill said that in every previous case with Specsavers this has led to the director exiting the business. Once the period of suspension had expired, the Registrant could apply to Specsavers for a Director's role but he would be required to participate in a full recruitment process and this would have to be in relation to a different store. Mr Ivill said to the Committee that whilst he understood the principles to arise out of the case of ***Bolton***, that it was his submission that the punitive impact of a suspension for the Registrant could be taken into account, but it may have a lesser effect than in other proceedings. Mr Ivill reminded the Committee that his primary submission was that a financial penalty would be appropriate and proportionate. He said that if the Committee decided to impose a period of suspension, that it should be for a short period. In terms of erasure, Mr Ivill submitted that in the circumstances, it would be wholly inappropriate and disproportionate to erase the Registrant's name from the register because the evidence did not indicate that his conduct was fundamentally incompatible with being a registered professional.

87. The Committee heard and accepted the advice of the Legal Adviser. She referred the Committee to the Council's Hearings and Indicative Sanctions Guidance and the purpose of imposing a sanction which included protecting the public, promoting, and maintaining public confidence in the profession and promoting and maintaining proper professional standards. She advised that the Committee must come to its own independent view and there was no burden or standard of proof at this stage of the proceedings.

88. The Legal Adviser advised the Committee that the sanction to be imposed should be appropriate and proportionate, balancing the Registrant's interests with the public interest and that whilst the purpose is not to punish the Registrant that it may have a punitive effect. In addition to identifying the aggravating and mitigating factors, the Committee was advised to assess its conclusions on the acts of dishonesty, to then consider the extent of the dishonesty and its impact on the Registrant's character and most importantly, in view of the Committee's findings on impairment, its impact on the wider reputation of the profession and the public perception of the profession. The Legal Adviser highlighted the case of ***Bolton v Law Society [1994]*** which provided that the reputation of the profession is more important than the impact for the individual member. The Legal Adviser advised the Committee that having regard to the cases of ***Raschid v GMC; Fatnani v GMC [2007]*** and ***GMC v Bawa-Garba (British Medical Association & Others intervening) [2019]*** which all upheld ***Bolton***, the Committee should be primarily concerned with the reputation or standing of the profession rather than any *'punishment'* caused to the Registrant by the imposition of a sanction.

89. The Committee was advised to consider the least restrictive sanction first and if not appropriate or proportionate, to move to the next available sanction in ascending order. The Legal Adviser invited the Committee to consider the next more restrictive sanction if there is one, before settling on a particular sanction to enable the Committee to satisfy itself that the sanction being considered is the most appropriate and proportionate. The Committee was advised to remind itself of paragraphs 21 and 22 of the Council's Hearings and Indicative Sanctions Guidance in terms of the available sanctions, factors to be taken into account, sanctions in cases of dishonesty and considerations for a review hearing.

The Committee's decision on sanction

90. In reaching its decision, the Committee took into account the submissions by Ms Birks and Mr Ivill, relevant documents including testimonials, the facts found proved and its previous decisions on misconduct and impairment.

91. Throughout its deliberations the Committee had regard to the overarching objective, particularly the promoting and maintaining of public confidence and the promoting and maintaining of proper professional standards.

92. The Committee considered the following to be mitigating factors:

(a) There was no harm caused to Patient A or any other patient.

(b) It was an isolated incident of dishonesty.

(c) The Registrant had demonstrated insight, remorse, reflection and targeted remediation.

(d) The Registrant had instigated coping strategies for himself and his colleagues to address stress in the workplace.

93. The Committee considered the following to be aggravating factors:

(a) The conduct had involved dishonesty in that the Registrant had deliberately amended Patient A's record and had not annotated it to reflect the amendments. He had included information in the amended text that he could not recollect.

(b) The Committee had regard to paragraph 14.3 of the Council's Hearings and Indicative Sanctions Guidance and having reminded itself of the circumstances that the Registrant had not informed his business partner of the amendments when he knew that his business partner was intending to respond to Patient A's complaint, determined that this was a failure to be candid with his colleague. The Committee found that the Registrant's actions meant that his dishonest behaviour had impacted on the process of a patient complaint.

94. It was the Committee's assessment that while dishonesty is serious, and an informed and reasonable member of the public would be concerned about the Registrant's actions, they would not consider it to be at the most serious end of the spectrum of dishonesty. The Committee reminded itself that whilst impairment had been found in this case, it had been found on the basis of the public interest element only and it had determined that the risk of repeat conduct was low.

95. In reaching its decision the Committee also took into account the fact that the Registrant had no previous fitness to practice history and had practised as an Optometrist without any further complaint after the misconduct.

96. The Committee first considered taking no action. It determined that there were no exceptional circumstances to justify so doing. Taking no action would not protect the wider public interest or reflect the seriousness of the misconduct.

97. The Committee carefully considered imposing a financial penalty and it reminded itself of the submissions made by Mr Ivill. The Committee had regard to the limited guidance at paragraph 21.11 of the Council's Hearings and Indicative Sanctions Guidance and took into consideration that this was not a case involving financial motivation or a financial benefit to the Registrant. Upon consideration of the aggravating factors of the misconduct it decided that a financial penalty would not be sufficient to protect the wider public interest element of the overarching objective because of the seriousness of the misconduct and the need to uphold and maintain public confidence in the profession and uphold and maintain proper professional standards. The Committee concluded that a sanction that did not involve removal from the register for a period would be insufficient in a case of dishonestly amending patient records retrospectively.

98. The Committee considered imposing a period of conditional registration and determined that this would be inappropriate in the circumstances because the Registrant's clinical competency had not been in question. It also determined that having regard to the nature of the misconduct that it would not be possible to formulate workable conditions.

99. The Committee next considered a period of suspension and the relevant sections of the Guidance which set out where suspension may be appropriate. It determined that parts a – d of paragraph 21.29 were engaged. The Committee noted that it had

determined that a lesser sanction would be insufficient; there was no evidence of attitudinal problems; there had been no recurrence; the Registrant had demonstrated insight and the Committee had determined that there was a low risk of repetition. The Committee found that the Registrant had taken positive steps to remediate his behaviour, had engaged with the regulator and accepted the findings of the Committee during the hearing. The Committee noted that the imposition of a suspension may cause the Registrant personal hardship in that as well as losing his ability to practise as an Optometrist, he might also lose his directorship of two Specsavers stores and attached appropriate weight to this. However the Committee also considered the case of ***Bolton v Law Society [1994]*** which provided that *'the reputation of the profession is more important than the fortune of any individual member.'*

100. The Committee determined that a period of suspension would reflect the seriousness of the misconduct and redress any damage to public confidence in the profession and would uphold proper professional standards.

101. In deciding on the length of the suspension, the Committee considered the seriousness of the misconduct and balanced this with the mitigating factors. It decided that a short suspension would be appropriate and proportionate in the circumstances. The Committee noted that the Registrant was a competent clinician, and it was in the public interest for him to return to practice as soon as appropriate. Further, the Committee had found that there was a low risk of repetition of the misconduct and current impairment had been decided only on the grounds of public interest.

102. To assist the Committee with its decision, the Committee went on to consider whether the criteria for the sanction of erasure were met and considered paragraphs 22.4 – 22.6 of the Guidance which related specifically to dishonesty. The Committee decided that the circumstances did not merit a finding that the Registrant's behaviour was fundamentally incompatible with continued registration. Further, the sanction of erasure was disproportionate in this case.

103. The Committee was satisfied having made this decision that the appropriate and proportionate sanction was a period of suspension for three months.

104. The Committee considered whether it was necessary to direct a review of the suspension. It considered paragraphs 21.32 – 34 of the Guidance and reminded itself that impairment had been found only on the grounds of the public interest. The Committee determined that in these circumstances and with particular reference to the mitigating factors, there were no matters relating to the Registrant's practice or conduct that needed to be reviewed prior to the Registrant safely returning to practise. The issue of public interest had been addressed by the imposition of a three month suspension order. The Committee therefore directed that no review of the suspension order was required.

Immediate Order

105. The Committee went on to consider whether having made a direction for a three month Suspension Order, it should make an immediate Order under section 13I of the Opticians Act 1989.

106. Ms Birks submitted that in view of the Committee's findings on misconduct and impairment that the Council was not seeking an immediate order. Mr Ivill agreed with the Council's approach and said that in view of the time that had elapsed since the

misconduct during which the Registrant had been working without restriction and with no concerns, that an immediate order was not necessary or appropriate.

107. The Committee heard and accepted the advice of the Legal Adviser. She referred the Committee to paragraphs 23.1 – 23.5 of the Council's Hearings and Indicative Sanctions Guidance. The Legal Adviser advised the Committee to have regard for the circumstances of this case, the Committee's findings particularly in relation to impairment and the fact that the Registrant had been working without restriction since the misconduct. She said that in line with the Guidance, having decided to impose a suspension order the Committee could order an immediate suspension if it was satisfied that it was necessary to do so for the protection of members of the public, otherwise in the public interest or in the best interests of the Registrant.

108. The Committee had regard to its prior decisions, in particular its decisions on impairment and sanction. The Committee determined that, there being no public protection concerns, the fact that the Registrant had worked unrestricted since the misconduct and given its reasoning for directing a sanction of a three month suspension order, that no immediate order was necessary.

Chair of the Committee: James Kellock

Signature  **Date: 21 November 2023**

Registrant: Rishi Patel

Signature present and received via email **Date: 21 November 2023**

FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase in due course.
Appeal
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
Professional Standards Authority
This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public. Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address). Further information about the PSA can be obtained from its website at www.professionalstandards.org.uk or by telephone on 020 7389 8030.
Effect of orders for suspension or erasure
To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.
Contact
If you require any further information, please contact the Council's Hearings Manager at 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.