BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(22)04

AND

MICHAEL MOON (01-9510)

DETERMINATION OF A SUBSTANTIVE HEARING
05 – 09 SEPTEMBER 2022
AND
12- 13 SEPTEMBER 2022

Committee Members:	Ian Crookall (Chair/Lay) Ben Summerskill (Lay) Asmita Naik (Lay) Sanna Nasrullah (Optometrist) Alexander Howard (Optometrist)
Clinical adviser:	None
Legal adviser:	Richard Price
GOC Presenting Officer:	Alex Lawson
Registrant present:	Mr Michael Moon
Registrant representative:	None
Hearings Officer:	Miss Nazia Khanom
Facts found proved:	1a, b, d, e, f, g, h, i & j 2a & b 3a, b, d, e, f 4a & b 5 6 in relation to dishonest
Facts not found proved:	1c & 3c

Misconduct:	Found
Impairment:	Impaired
Sanction:	Conditions of Practice imposed for 3 years with review in 12 months
Immediate order:	Approved

ALLEGATIONS

The Registrant, Michael Moon, appeared before the Committee to face the following Allegations:

1. On or around 29 May 2019, you failed to conduct an appropriate examination of Patient 3's eyes in that you:

a. Failed to perform a visual fields test;
b. Failed to record a visual fields test;
c. Failed to perform IOP measurements;
d. Failed to record IOP measurements;
e. Failed to perform muscle balance or binocular vision test;
f. Failed to record muscle balance or binocular vision test;
g. Failed to perform an internal examination of the eyes;
h. Failed to record an internal examination of the eyes;
i. Failed to perform an external examination of the eyes;
j. Failed to record an external examination of the eyes.

2. On or around 12 June 2019, you failed to conduct an appropriate examination of Patient 8's eyes in that you:

a. Failed to perform examinations for the external eyes;
b. Failed to record examinations for the external eyes.

3. On or around 9 July 2019, you conducted a sight test on Patient 2 and behaved inappropriately by:

a. Referring to Patient 2 as a “child” or words to that effect;

b. Referring to Patient 2 as a “lady of leisure” or words to that effect;

c. Referring to Patient 2 as a “lady who lunches” or words to that effect;

d. Making remarks to Patient 2 about “women using headaches as excuses” or

e. words to that effect;

f. Making remarks to Patient 2 about how you conducted “market research with

g. women before proposing to your wife” or words to that effect; and/or

h. f. Stating to Patient 2’s boyfriend “I will take her off your hands” or words to that effect.

4. On or around 16 July 2019, you failed to perform an appropriate examination of Patient 6’s eyes in that you:

a. Failed to perform examinations for the external eyes;

b. Failed to record examinations for the external eyes.

5. On or around 6 August 2019, you amended Patient 9’s records for the sight test you conducted on or around 10 July 2019 by inputting details into the ophthalmoscopy section.

6. Your action at 5 above was dishonest and/or misleading in that you did not record that the amendments were made retrospectively.

DETERMINATION

Admissions in relation to the particulars of the allegation

1. The Registrant was not represented. The GOC was represented by Alex Lawson of Mr Lawson.
2. At the outset of the hearing, the Registrant admitted the following allegations of fact:1(a) and (b), 1(e) to (j) and 2(b), 4(b) and 5.
3. Accordingly, the admitted facts were found proved by the Committee.
4. The allegations which remain in issue are 1(c) and (d), 2(a), 3(a)-(f), 4(a) and 6.
5. The Registrant joined the GOC as a registered optometrist on 22 October 1976 (GOC Number 01-9510). At the material time, the Registrant was employed by Vision Express Opticians as an Optometrist at its redacted store. He has been in practise for over 40 years.
6. On 27 September 2019, the Registrant self-referred to the GOC, setting out that he had received three complaints in a short period of time, 2 of which subsequently became Allegations 1 and 3. Following an internal disciplinary process within Vision Express, the Registrant was dismissed from his employment on or around 4 October 2019. On the same date, the GOC was given notice of the fact that the Registrant had

been dismissed from his employment with Vision Express and was provided with a copy of the disciplinary letter outlining the employer's concerns as to the Registrant's conduct.

7. By letter dated 6 June 2022, the Registrant was served with a Notice of Inquiry, containing the allegations against him, and giving him notice that the substantive hearing would take place from 5 September 2022 – 13 September 2022.

8. The Committee will now summarise the relevant facts underlying the various allegations.

Findings in relation to the facts

Allegation 1 (a) - (j)

1. These allegations arise following a complaint received by Vision Express from Patient 3, following an appointment that she had attended with the Registrant on 29 May 2019. A summary of Patient 3's complaint is as follows:

   i. When Patient 3 arrived for the appointment, rather than being asked to enter the room she was left standing in the doorway, and needed to ask the Registrant if she should sit down (making her feel overlooked and disregarded).

   ii. The Registrant did not obtain a comprehensive history or ask Patient 3 any questions about her vision other than to ask her whether her reading glasses were sufficient for her hobbies.

   iii. No refraction was performed.

   iv. A trial frame and lenses were not used when testing Patient 3's distance vision, she was simply asked to read the chart with her spectacles on.

   v. The Registrant did not perform any ocular examination of Patient 3's eyes. At the end of the test, the Registrant said words to the effect of "That's the easiest one I've done today", which Patient 3 felt was inappropriate as the Registrant had not 'shone' a light into her eye or used the equipment on the table to her left (i.e. the slit lamp).

2. The Committee has seen the records for Patient 3's visit on 29 May 2019, and notes that none of the details referred to above were recorded, suggesting that no external examination or internal examination was carried out. The Committee notes that the Registrant has admitted all these allegations, except 1(c) and (d).

Allegation 3 (a)-(f)

3. These allegations arise from a complaint received by Vision Express from Patient 2, following an appointment that she had attended with the Registrant on 9 July 2019. The complaint was included with a customer satisfaction survey completed by Patient 2 dated 15 July 2019. Patient 2 was very upset about the eye appointment that she had with the Registrant, when she claims that the Registrant made the various comments set out in the allegations, which she contended were inappropriate. The Committee notes that the Registrant denies these allegations.

Allegations 2(a) and (b), and 4(a) and (b)

4. These allegations arise from an audit of the Registrant's cases, carried out by Vision Express following receipt of Patient 3's complaint. The audit was carried out by Mr A on 17 July 2019, and provide the basis for Allegations 2 and 4, as set out above.

Allegations 5 and 6

5. These allegations arise from an incident which occurred during a break in a disciplinary hearing held into the Registrant's conduct by Vision Express on 6 August 2019. This hearing was conducted by Mr B, the Store Manager of the Vision Express branch in redacted. Mr A attended the hearing as a note-taker.

6. During this break, Mr A found the Registrant, in the consultation room he would usually use, with the records for Customer 27010 (corresponding to patient 9) open on his computer screen, and a copy of the audit results on his desk. The Registrant had performed an examination for this patient on 10 July 2019, and the records of the examination were among the records that Mr A had audited. They showed that no record of an internal examination had been made.

7. The Registrant queried this, and showed Mr A the records of the customer's appointment, which showed the results of ophthalmoscopy on that date. Mr A was certain that the Registrant's record had not included a record of ophthalmoscopy when he performed the audit. So, he opened the Acuitas audit trail to determine when the records of ophthalmoscopy on 10 July 2019 had been made. The audit trail showed that entries in respect of ophthalmoscopy in the record of this customer's appointment on 10 July 2019 were made on 6 August 2019 at 12.38.20. The record showed that the changes had been made using the Registrant's Access PIN on the computer in the upstairs consulting room usually used by the Registrant and where he was sitting at the time the changes were made.

8. The Committee notes that the Registrant has admitted Allegation 5, but denies allegation 6, which alleges that his actions were dishonest or misleading.

The evidence before the Committee on Facts

<u>Mr A</u>

9. The Committee received written and oral evidence from Mr A of Vision Express redacted. Mr A made a witness statement dated 17 December 2021, in which he explained the facts leading up to Allegations 1-6 above and exhibited various documents in support.

10. Mr A explained to the Committee that he had worked continuously in the redacted store since September 2015 and became the retail manager of the store in early July 2019. His responsibilities as the retail manager for the store included carrying out performance reviews, organising training, cashing up and stock-taking, performing audits of customer records, and complaint resolution. He explained that Vision Express operated a computerised system for recording customer records called Acuitas, which included an audit trail from which it was possible to ascertain when entries onto the Acuitas system had been made and by whom. Mr A had experience of this system going back over 10 years.

11. Mr A made his witness statement in relation to (a) his investigation of the three patient complaints about the Registrant in July 2019, (b) the audit that he carried out on 17 July 2019 of a set of 10 patient records made by the Registrant, (c) and the disciplinary

hearing which was held for the Registrant on 6 August 2019 and the events of that day, referred to above.

12. In relation to Allegation 1, Mr A exhibited a copy of the eye examination records in respect of Patient 3's eye examination by the Registrant on 29 May 2019, and her follow-up eye examination on 17 July 2019. The records under the examination tab of the records for this Patient on 29 May 2019 revealed that no details were completed on the pages relating to visual field-testing intraocular pressure measurements muscle balance or binocular vision test internal examination or external examination. This suggested that these parts of the eye examination were either not performed, not recorded, or both.

13. In relation to allegation 3, Mr A exhibited a copy of a customer satisfaction survey completed by Patient 2, which set out in detail the various comments made to her by the Registrant, which she considered made her feel uncomfortable during the eye appointment, and which she considered to be inappropriate, as detailed in allegation 3.

14. In relation to Allegations 2 and 4, Mr A produced the record of the audit that he carried out on 17 July 2019, and a copy of the records that were audited. The audit revealed gaps in the Registrant's clinical performance and record keeping, in that the Registrant had either not performed clinical examinations that he would have been expected during a full eye examination or had not recorded the results of these tests in his patient records.

15. In relation to Allegation 5, in his witness statement, Mr A gave a detailed explanation of what happened during the break in the disciplinary hearing carried out by Vision Express on 6 August 2019. He also gave the Committee a detailed demonstration of how the Acuitas record system worked, by reference to various screenshots of the audit trail, which showed that entries in respect of ophthalmoscopy in the record of Customer 27010's appointment on 10 July 2019 were made on 6 August at 12.38.20, and this occurred 4 minutes after the disciplinary hearing had adjourned. The audit trail showed that the changes had been made using the Registrant's PIN, on the computer with identity number redacted, which was the computer in the Registrant's usual consulting room, where he was found by Mr A. The Registrant drew Mr A's attention to the record and suggested to him that the Registrant had recorded the relevant information on the day of the appointment. This led Mr A to undertake an investigation into the audit trail in relation to the entries and screenshots were taken.

16. Mr C, who was conducting the disciplinary enquiry into the Registrant's conduct, showed the Registrant the screenshots that had been taken. The Registrant denied that he had amended the record, and said that all he had done was to look at each of the records, and that "If it has happened I've done it inadvertently".

17. Mr A explained in his witness statement and in his oral evidence that he had since considered the possibility that the Registrant might have inadvertently copied the previous records. However, he did not believe that would have been possible as there are three steps that need to be taken to copy a set of entries from the previous record. The optometrist must first click the "copy previous" function, then must select the date of the record they wish to copy. Finally, they must click "OK" to confirm the insertion.

18. The Committee repeats that, at the outset of the hearing, the Registrant admitted Allegation 5.

19. The Committee considered that Mr A was an excellent witness. In particular, he demonstrated a detailed understanding and explanation as to how the Acuitas system, and its audit trail, worked. He knew the Registrant well and went out of his way to be fair to him in the evidence he gave. The totality of his evidence was detailed, cogent and helpful in relation to the allegations. The Committee found him to be a credible and reliable witness, who gave considerable assistance to the Committee in understanding the complexities of this case.

Patient 3

20. The Committee also received written and oral evidence from Patient 3, who produced a written witness statement in relation to allegation 1 dated 23 March 2020. In her oral evidence, Patient 3, explained what happened when she attended the eye examination by the Registrant on 29 May 2019. The Committee noted that the Registrant admitted all of Allegation 1, except 1(c) and (d), namely failing to perform and record IOP measurements. Patient 3 explained to the Committee that, before she was seen by the Registrant, she went downstairs where an optical assistant performed a test, which she described as a "puffer" test in which air was blown into her eyes. It seemed to the Committee that this was an IOP test. However, there is no other evidence of such a test having been performed either by the optical assistant or the Registrant and it was not recorded in the patient record.

21. Patient 3 explained that she had worn glasses for over 40 years, and was familiar with the normal eye tests that she expected to have been performed, particularly for someone with a family history of glaucoma. She gave clear evidence that the various tests set out in the remaining tests in Allegation 1 were not performed by the Registrant, and that she was never told what the results of the IOP tests were.

22. The Committee considered that Patient 3 was a credible and reliable witness, who gave helpful evidence, and was doing her best to assist the Committee in its deliberations.

Patient 2

23. The Committee received written and oral evidence from Patient 2, who produced a written witness statement in relation to this matter dated 26 March 2020. This Patient was seen by the Registrant at an eye appointment on 9 July 2019. The complaint was first set out in the customer satisfaction survey completed by Patient 2 dated 15 July 2019, a week after the appointment. The complaint relates to a number of comments made by the Registrant when she attended the appointment, which she said were inappropriate, and made her feel uncomfortable. The comments about which complaint was made are detailed in the customer satisfaction survey and are set out in Allegation 3 (a) – (f). Patient 2 was of the view that the Registrant " displayed some clear signs of entitlement in how he speaks and interacts with young women". Her witness statement ran to some six pages, in which Patient 2 expanded on her concerns, and stated in conclusion:

"I would like to emphasise that the purpose of my complaint was not to get [the Registrant] in trouble, Far (sic) from it, but to instead ensure that someone tells him

that this behaviour is simply not appropriate – particularly when in a professional context."

24. The Committee considered that Patient 2 gave a balanced account of the events that occurred during the appointment, and she considered the matter carefully before she decided that it would be right to make a formal complaint. The Committee considered that Patient 2 was a credible and reliable witness, who gave helpful evidence, which assisted the Committee in fully understanding the extent of her concerns.

Written evidence

25. At the conclusion of the GOC's case, Mr Lawson asked that the witness statement of Mr C (dated 30 June 2020), who was the store manager of Vision Express – redacted, which produced an exhibit of an interview of the Registrant which was conducted on the 9 September 2019, and an exhibit of the Registrant's dismissal letter sent by Vision Express on 19 September 2019, be read into the record. This was agreed by the Committee.

26. Mr Lawson for the GOC also asked that an expert report on the conduct of the Registrant by Mr Lyndon Taylor BSc (Hons) FCOptom, dated February 2022, be read into the record. This was agreed by the Committee.

The Registrant

27. The Registrant gave evidence on his own behalf but had not submitted a witness statement. He was cross-examined by Mr Lawson for the GOC and questioned by the Committee.

28. He was an experienced optometrist, who had been in practice for over 40 years. He gave the Committee a brief resume of his career during that time. He had no adverse professional or other findings against him. He wanted to be helpful to the Committee and admit where things went wrong. He was flexible in his approach, having heard the evidence from the witnesses. Mr A, in his evidence, informed the Committee that the Registrant was a much-respected optometrist.

29. He was generally remorseful about what had occurred. However, he became aware of the complaints after he had dealt with a large number of patients, and his recollection of events was limited in the absence of certain recorded notes. The Committee considered that, being unrepresented, he did not appear to fully appreciate the import of these proceedings. Although he denied many of the allegations, it was clear from his evidence that he did not dispute them.

30. He continued to assert that the insertions he made in the Acuitas computer system on 6 August 2019 were accidentally incorporated. In the face of clear evidence that he had made the insertions himself, he offered no plausible explanation for what had happened. He admitted allegation 5, namely that he had amended the relevant records as alleged.

The Decision of the Committee on the Facts

31. The Committee has read and carefully considered all the evidence in this case, including all the documentary evidence in the Inquiry Bundle. It has heard and taken into account the closing submissions of Mr Lawson for the GOC, and the brief closing submissions made by the Registrant. The Committee has accepted the advice of the Legal Adviser. In particular, the Committee accepted the advice of the Legal Adviser that it should assess the credibility and reliability of the evidence of the witnesses who gave oral evidence, and how it should approach the allegation of dishonesty. The Committee will deal with each of the allegations in turn.

Allegation 1

32. All of the individual allegations in Allegation 1 were admitted by the Registrant at the outset of the hearing, except for allegations 1(c) and (d). In his oral evidence to the Committee, the Registrant explained that IOP measurements were done by an Optical Assistant in advance of the main eye examination that should have taken place with the Registrant. What should have happened was that the Assistant should have recorded the results of the IOP measurements, either on the computer system, or in writing to the Registrant. The Registrant admitted in evidence that he was unable to say whether the IOP measurements were in fact taken from Patient 3. He admitted Allegation 1(d), and accepted that he had not recorded any IOP measurements, and that it was his responsibility to ensure that they were taken and recorded.

33. The Committee accepted the evidence of Patient 3, who explained that she was seen by an Optical Assistant, before she saw the Registrant, and described how she had undergone the "puffer" test, when air was blown into her eyes. That was the test to measure intraocular pressure within the Patient's eyes, which was particularly necessary in this case, because of family history of glaucoma. However, it is clear that the results of this test were never recorded by the Registrant.

34. In these circumstances and given that there was evidence of the IOP test having been performed, the Committee was unable to find that Allegation 1(c) as worded was proved by the GOC on the balance of probabilities

Allegations 2 and 4

35. The Registrant admitted Allegations 2(b) and 4(b), in relation to Patient 8, and Patient 6 (failing to record examinations for the external eyes), but denied that he had failed to perform such examinations. The Committee listened to the oral evidence given by the Registrant in relation to these allegations, and considered that he appeared to have taken a relaxed approach to the external examination of these Patient's eyes, rather than taking an organised and structured approach to this aspect of the eye test. He appeared to say that the other tests he undertook enabled him to assess the exterior of the eye. In short, the Committee considered that the Registrant was insufficiently rigorous in carrying out this aspect of the eye tests, saying that he tended to rely on patients complaining about symptoms before carrying out a full external eye examination. In relation to Patient 8 the Committee noted that the patient was a 13-year-old child. The Committee noted that the Registrant had admitted that he had not examined the external eyes of Patient 3. In any event, there was no contemporaneous evidence by way of records that these examinations had taken place.

36. Accordingly, the Committee finds that, on the balance of probabilities, Allegations 2(a) and 4(a) were proved.

Allegation 3

37. The Committee found Patient 2 to be a credible and reliable witness. Her initial account of the comments about which she complained were initially set out in her customer satisfaction survey, which was recorded within a week of the eye examination conducted by the Registrant on 9 July 2019. She elaborated on this matter in some detail in her lengthy witness statement dated 23 March 2020.

38. The Registrant initially denied all the sub-allegations in Allegation 3. In her written and oral evidence, Patient 2 explained the context in which the relevant remarks were made. Allegation 3(a) (referring to her as a "child") was in the context of the Registrant saying that she was younger than his daughter. Patient 2 explained that Allegations 3(b) and 3(c) (referring to her as a "lady of leisure", and as a "lady who lunches") were in the alternative. In her satisfaction survey, Patient 2 said the comment was "lady of leisure", but in her witness statement said the comment was "lady who lunches". Patient 2 accepted that her memory of events when she filled out the survey was likely to be more accurate than when she made her witness statement, or at the date of the hearing. Having heard the totality of Patient 2's evidence, the Committee considers that, on the balance of probabilities, the comment about which complaint is made was likely to be "lady of leisure". This was said when Patient 2 said she was unable to drive.

39. When the Registrant gave his evidence, he said he could not remember the comment about a "child" or "lady of leisure". He said that he had always intended to admit allegation 3(f) (saying to the boyfriend "I will take her off your hands", in the context of Patient 2's appearance when wearing the new spectacles she had chosen). As to the remaining Sub-Allegations (3(d) – "women using headaches as excuses", and 3(e) conducting "market research with women before proposing to your wife", the Registrant appeared to accept that he probably did make these comments, or words to that effect.

40. The Committee has no doubt that Patient 2 was very upset about the comments made to her during the eye examination, and she considered them to be inappropriate, particularly when made to a "young woman", and unprofessional. The Committee notes that Patient 2 reflected carefully on whether she should make this complaint but was still sufficiently concerned a week after the event about what had occurred that she decided to fill out the satisfaction survey.

41. The Committee notes that the Registrant apologised to Patient 2, during the hearing of this matter, which is to his credit. However, the Committee finds that, on the balance of probabilities, the comments made by the Registrant and set out in allegation 3 were made as Patient 2 describes. The Committee considers that this was a case of a male Registrant making inappropriate remarks to a female patient that were perceived to be condescending. Such conduct was unprofessional. Accordingly, the Committee found allegation 3 proved with the exception of Allegation 3d.

Allegations 5 and 6

42. The Committee accepted the advice of the Legal Adviser that the test for dishonesty is set out in the case of *Ivey v Genting Casinos (2017).* When dishonesty is in question the Committee must:

(1) First ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts.

(2) When his state of mind as to knowledge or belief as to factors established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying (the objective) standards of ordinary decent people.

43. The Registrant has admitted that he amended Patient 9's records for the sight test that he conducted on or around 10 July 2019 by inputting details into the ophthalmoscopy section (Allegation 5). However, he denies that his action was dishonest and/or misleading in that he did not intend that the insertion's were made deliberately (Allegation 6).

44. The Committee has accepted the detailed evidence of Mr A in relation to the operation and workings of the Acuitas system, and the audit trail within it which enables the operator to ascertain who inputted changes into earlier records and when. The Committee has accepted Mr A's evidence that the Registrant inputted changes into the ophthalmoscopy section of the relevant record, using his own PIN on the computer that he usually used. The Registrant accepted Mr A's statement that there were no known glitches in relation to updating records. The Committee has accepted his evidence that these inputted changes could not have been done accidentally. The Registrant has not been able to provide any explanation as to how the entries could have been made by him without his action being deliberate.

45. The Committee accepts that the Registrant has an unblemished record going back 40 years, and that it is entitled to take that fact into account when deciding this matter. The Committee also notes that this incident occurred in stressful circumstances, during a break in a disciplinary hearing. The relevant information was inputted within four minutes of the hearing adjourning at 12:34pm. The Registrant acknowledged, by his admission of Allegation 5, that he was the only person who could have made the changes to the record. The Committee considers that there is no plausible way in which the Registrant could have done this unwittingly, or accidentally. Accordingly, the Committee finds that (subjectively) the Registrant must have known that what he had done was wrong. That being the case, the Committee has no doubt that the Registrants conduct was dishonest by applying the (objective) standards of ordinary decent people.

46. Accordingly, the Committee finds that Allegation 6 is proved on the balance of probabilities on the basis of dishonesty.

Findings in relation to misconduct

47. The Committee next had to decide whether it considered that the allegations found proved amounted to misconduct. The Committee received submissions on this matter from Mr Lawson for the GOC, and from the Registrant.

48. The Committee accepted the advice of the Legal Adviser, which is summarised below.

49. There is no statutory definition of misconduct. The Committee had to exercise its judgement to determine whether an act or omission amounted to misconduct.

50. In *Roylance v GMC [1999]* misconduct was described as:

    "A falling short by omission or commission of the standards to be expected among [medical practitioners] and such falling short must be serious."

51. Mr Lawson for the GOC referred the Committee to the cases of *R (Calheim) v General Medical Council (2007)* and *Remedy UK Ltd v General Medical Council (2010).*

    Taken from the case-law, the test for misconduct is that the conduct of the Registrant must amount to serious professional misconduct, or conduct that falls far short of the standard to be expected from a reasonably competent optometrist.

52. Although the Committee should consider whether the individual allegations found proved amounted to misconduct, it is entitled to conclude that, individually or cumulatively, the Registrant's conduct amounted to misconduct.

53. Allegations 1, 2 and 4 related to clinical failings. Allegation 3 is in a different category, in that it arises out of a series of inappropriate comments made to Patient 2 in the course of a sight test appointment. Allegations 5 and 6, involve an allegation of dishonesty, namely improperly amending the detail on a patient's record retrospectively.

54. The Committee is aware of the relevant facts that were found proved in its previous Decision on Facts, and it is for the Committee to decide whether the Registrant's conduct as found proved, amounted to serious professional conduct, or fell far below the standard to be expected from a reasonably competent optometrist.

55. In coming to its decision on this matter, the Committee considered the Expert Report on the Registrant, prepared by Mr Lyndon Taylor BSc (Hons) FCO Optom, dated February 2022. However, members of the Committee are entitled to apply their knowledge and experience, and do not have to accept the views put forward by the expert. The Committee's task is to set and apply appropriate standards, a function which is not to be delegated to an expert, although of course an expert opinion respectful consideration.

56. In determining misconduct, the Committee had regard to the GOC's Standards of Practice for Optometrists and Dispensing Opticians ("Standards").

<u>Allegations 1, 2 and 4</u>

57. These allegations involve clinical failings. The Committee notes that Standards 7 ("Conduct appropriate assessments, examinations, treatments and referrals") and 8 ("Maintain adequate patient records") are engaged in relation to these allegations. The Committee considered that Allegation 1 was very serious, because it involved flagrant breaches of Standards 7 and 8, which might have resulted in a risk of harm to any patient, but especially Patient 3, who had a known family history of glaucoma. The Registrant was in breach of Standards 7 and 8. The Committee considered that the Registrant's conduct in relation to Allegation

1 fell far short of the standards to be expected of a reasonably competent optometrist in general practice.

58. The Committee noted that Allegations 2 and 4 also involved breaches of Standards 7 and 8, but were less serious because they only related to individual failings in relation to external examinations of the eyes of Patient 6 and 8. It was the view of the Committee that, taken alone, these Allegations involved conduct on the part of the Registrant which fell below the standard expected. However, when taken together with Allegation 1, the Committee considered that the Registrant's conduct in relation to Allegations 2 and 4 fell far below the standard expected of a reasonably competent optometrist.

59. Accordingly, the Committee considered that the facts found proved in relation to Allegations 2 and 4 amounted to misconduct.

Allegation 3

60. This allegation involved the Registrant making inappropriate remarks to Patient 2, a female patient, which were unprofessional, and caused the patient to feel uncomfortable. The Committee notes that Standards 13 ("Show respect and fairness to others and do not discriminate") and 15 ("Maintain appropriate boundaries with others") are engaged in relation to this allegation. The Registrant was in breach of Standards 13 and 15. It was the view of the Committee that each of the inappropriate comments in Allegation 3, when taken individually, involved conduct on the part of the Registrant that fell below the standard to be expected of a reasonably competent registered optometrist. However, when all the inappropriate comments in Allegation 3 were taken together, they gave a negative impression of the profession, and fell far below the standard expected of a reasonably competent optometrist.

61. Accordingly, the Committee considered that the facts found proved in relation to Allegation 3 amounted to misconduct.

Allegations 5 and 6

62. Taken together, Allegations 5 and 6 amounted to a finding of dishonesty, namely improperly amending the detail on patient records, without recording that the amendments were made retrospectively. The Committee noted that Standards 16 ("Be honest and trustworthy") and 17 ("Do not damage the reputation of your profession through your conduct") were engaged. These allegations amounted to clear breaches of standards 16 and 17. The Committee was of the view that the Registrant's conduct in relation to these allegations involved failing to uphold professional standards and public confidence in the profession.

63. Accordingly, the Committee considered that these allegations were serious and fell very far short of the standards to be expected from a reasonably competent optometrist.

64. In reaching these conclusions on misconduct, the Committee applied the legal principles outlined above, and its findings broadly echoed the views of the expert witness who provided a report in this case.

Findings regarding impairment

65. The Committee decided that Allegations that have been found proved amount to misconduct. It is now for the Committee to determine whether, by virtue of the misconduct, the Registrant's fitness to practise is currently impaired as of the date of this hearing.

66. The Committee received submissions on this matter from Mr Lawson for the GOC, and from the Registrant. The GOC submitted that the Registrant's fitness to practise is currently impaired.

67. The Committee accepted the advice of the Legal Adviser, which is summarised below.

68. Mr Lawson for the GOC referred the Committee to various authorities which considered the appropriate approach for panels considering current impairment. These cases included *CHRE v (1) NMC and (2) Grant (2011),* which considered the approach of Dame Janet Smith in the Shipman enquiry. She formulated the following relevant questions:

    "*Do the findings of fact in respect of the misconduct ...show that [the Registrant's] fitness to practice is impaired in the sense that he:*

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

    b) *has in the past brought and/or is liable in the future to bring the… profession into disrepute;*

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

    d) *has in the past acted dishonestly and/or is liable to act dishonestly in the future?"*

69. Mr Lawson for the GOC submitted that limb (a) may have been engaged, on the basis of risk of harm, and that limbs (b) – (d) are engaged in this case.

70. The Mr Lawson referred to *Cohen v GMC (2008),* in which Silber J gave the following guidance:

    "It must be highly relevant in determining if a doctor's fitness to practice is impaired that first his or her conduct which led to the charge is easily remediable, second that it has been remedied and third that it is highly unlikely to be repeated."

71. Mr Lawson also referred to *Cheatle v GMC (2009),* and *Yeong v GMC. (2009). The Committee should consider the quoted passages from those cases.*

72. Mr Lawson then referred to CHRE v Grant (2011), in which Cox J noted:

    "In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the publicin his or her current role, but also whether the need to uphold professional standards and

public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances"

73. Mr Lawson finally submitted that, in considering Dame Janet Smith's principles, the case of Grant, the need to uphold professional standards and maintain public confidence in the profession is paramount. Having regard to misconduct found by the Committee, Mr Lawson submitted that a finding of no impairment would wholly undermine public confidence in the profession.

74. In reaching a decision on current impairment, the Committee must consider the extent to which it thinks that the Registrant has demonstrated insight into his misconduct, the extent to which he has learned from his mistakes, and whether the Committee considers that there is a risk that he might repeat his transgressions in the future. In addition, the Committee will wish to consider the extent that a finding of impairment is necessary in order to uphold professional standards and maintain public confidence in the profession.

Allegations 1,2 and 4

75. So far as the risk of harm is concerned, the Committee considered that the Registrant's failings in conducting examinations and maintaining adequate patient records potentially placed these patients at risk of harm, in that possible complications or problems may have been missed. The clinical failings should be remediable. The Committee considered that Standards 7 and 8 are fundamental tenets of the profession. However, although the Registrant says that he has attended courses in relation to record-keeping and completed copious amounts of Continuing Education and Training, he has not produced any written evidence to the Committee to verify the frequency and extent of these activities. He also mentioned changes to his procedures without producing documentary evidence. In relation to these clinical failings, the Committee considers that the Registrant has demonstrated some insight into these failings but is of the view that he still has some way to go in the future to achieve full insight into what is required. Accordingly, in relation to these allegations, the Committee considers that the Registrant's fitness to practise is currently impaired.

Allegation 3

76. In relation to the Registrant's conduct in making inappropriate remarks to Patient 2, the Committee considers that this conduct again should be remediable in time. The Committee noted the Registrant's apology to Patient 2 and his expression of remorse for his actions. However, while the Registrant has shown some evidence of reflection in relation to these matters, he has not explained clearly how he intends to remedy his ability to understand when comments are inappropriate and liable to cause patients to feel uncomfortable. The Registrant has demonstrated no structure of how he plans to avoid behavioural problems in the future. He has not shown evidence that he has now developed the skills required to build a rapport with patients, without overstepping boundaries and becoming overfamiliar. The only evidence that he has given on this aspect of the matter is to say that he has discussed the relevant allegations with his wife, who was an optometrist, and with his daughter. The Registrant has not given any evidence that he has

discussed these matters either with professional colleagues, carried out reading or undertaken any relevant training courses into behavioural matters. Again, the Committee considered that the Registrant has some way to go in the future to achieve full insight into what is required. In addition, the Committee considered that the Registrant's conduct in relation to this matter was likely to bring the profession into disrepute, and it is necessary for the Registrant to take steps to ensure that this impression is not repeated in the future. Accordingly, in relation to this allegation, the Committee considered that the Registrant's fitness to practise is currently impaired.

Allegations 5 and 6

77. These allegations of dishonesty are serious. The Committee thinks it important to record that it is taken into account the fact that the Registrant has an unblemished record of over 40 years in practice. In addition, it is in his favour that Mr A gave evidence to the Committee that he had known and worked with the Registrant for some time and found him to be a very experienced and popular optometrist, and his failings were out of character. The Registrant submitted that he would be able to find a number of positive testimonies, but he did not provide evidence of these to the Committee.

78. The Committee was prepared to accept that this act of dishonesty on the part of the Registrant was out of character and was an isolated incident in the midst of a stressful moment.

79. The Committee considered that the chance of repetition of the Registrant's dishonest conduct in the future is very low. However, the Committee considered that the Registrant still did not seem to understand why this was a very serious matter, even if it was an aberration.

80. Although the Committee recognised that the Registrant is not likely to act in this way again, the Committee considered that he had not yet developed sufficient insight into what he had done. The Committee considered that he had not yet fully appreciated the significance or consequences of manipulating records, the result of which was to deceive those reading them. The Committee was of the view that the Registrant had some way to go before he was able to accept the seriousness of his conduct, and the extent to which such conduct had brought the profession into disrepute.

81. Accordingly, the Committee considered that, in relation to these Allegations, the Registrant's fitness to practise is impaired.

Conclusion

82. The Committee has concluded that the Registrant's conduct is currently impaired in relation to all the Allegations. The Committee also considered that a finding of impairment is necessary on the basis of public protection and in the public interest so that professional standards are upheld and public confidence in the profession is maintained.

Sanction

83. The Committee next considered the question as to what, if any, sanction should be imposed on the Registrant, having regard to the misconduct and impairment already found.

84. The Committee considered the submissions made on behalf of the GOC, and on behalf of the Registrant. It has accepted the advice of the Legal Adviser. The GOC submitted that the appropriate sanction should be the imposition of conditions on the Registrant's registration, in view of the extensive mitigating features in this case.

85. The Committee bore in mind that it should have regard to the principles of proportionality, and balance the interests of the public against those of the Registrant. It was reminded that public interest considerations include protecting the public, maintaining public confidence in the profession, and maintaining proper standards of conduct and behaviour.

86. The Committee was guided by the Indicative Sanctions Guidance, November 2021 edition.

87. The Committee was advised by the Legal Adviser that there is a sliding scale of dishonesty, ranging from the more serious forms of dishonesty involving fraud and financial gain, to less serious forms which merely undermine trust to a greater or lesser extent. The Committee must decide where on a properly nuanced scale of dishonesty the misconduct falls.

88. The Committee was reminded that the purpose of any sanction is not to punish, but to protect patients and the wider public interest.

89. Mr Lawson for the GOC submitted that there were a number of significant mitigating factors in this case. These included: the act of dishonesty, on a sliding scale, was at the lower end of the scale; it was an isolated incident which took place in very stressful circumstances; the Registrant had an unblemished record over 40 years; he had apologised at the hearing to the Patients who gave oral evidence, and he showed remorse for his failings. He submitted that the Registrant's clinical and behavioural failings could be remediated, through development of further insight into his misconduct. He further submitted that the imposition of conditions, with supervision, would assist the Registrant's remediation process. The Mr Lawson for the GOC submitted that both suspension and erasure would be excessively draconian measures.

90. The Registrant responded to the submissions of the GOC. He accepted the findings of the Committee, including the finding of dishonesty. He accepted that he needed further education as to record keeping, clinical assessment, and interaction with patients. He explained to the Committee how he was now in practice with his wife, who was also an optometrist, and a dispensing optician. He told the Committee that he had developed an improved format for record cards

and amalgamated external examinations of the eye with slit lamp examinations, which he submitted would improve the services that he gave to his patients. He said that his act of dishonesty was most unlikely to be repeated. He informed the Committee that each year he normally achieved about a hundred CET points in each 3 year cycle, well above the minimum requirement of 36 points.

91. The Committee accepted that there were a number of mitigating circumstances in this case, as outlined by Mr Lawson for the GOC. In the view of the Committee, the key aggravating features were the limited insight shown and the fact that the Registrant placed reliance on his act of dishonesty for a long period of time. It was however an isolated act of dishonesty which the Registrant recognised in his final submissions. The Committee noted paragraph 22.4 of the Indicative Sanctions Guidance (the ISG) which indicated that there is no blanket rule or presumption that erasure is the appropriate sanction in all cases of dishonesty. The Committee accepted the GOC's submission that this principle also applies to suspension. Each case must be decided on its own facts, the circumstances of the case, and whether a lesser sanction is sufficient to satisfy the public interest.

92. The Committee noted the available sanctions following a finding of impairment, as set out in paragraph 21.2 of the ISG. The Committee considered those sanctions in ascending order of severity, beginning with taking no further action. The Committee was in no doubt that taking no further action would not be appropriate in this case. The Committee considered that a financial penalty was not appropriate having regard to the facts of this case.

93. The Committee next considered whether the imposition of conditions on the Registrant's registration would be sufficient to protect patients and the wider public interest. In a case where an act of dishonesty was found, the Committee would have expected a more restrictive sanction, at least suspension, would be required to mark dishonest behaviour. However, the Committee accepted that such a sanction did not automatically follow.

94. The Committee gave careful consideration to the mitigating factors set out above. The Committee also placed considerable weight on the evidence of Mr A, of Vision Express, who had worked with the Registrant for some time. He found the Registrant to be a very experienced and popular optometrist and considered that his failings were out of character.

95. The Committee understood that conditions must be appropriate, proportionate, workable and measurable. The Committee discussed the various types of conditions that would be necessary in this case. They included requiring the Registrant to undergo appropriate training courses in relation to record-keeping, and behavioural matters, and requiring him to be supervised by a mentor who was not a member of the Registrant's family, or a close friend. The Committee was of the view that, if conditions were to be imposed, they should be imposed for a period of 3 years.

96. The Committee considered that, if the Registrant were to be suspended, he would not have interaction with patients during the period of his suspension, and would, therefore, not be able to engage in the necessary process of remediation.

97. The Committee has concluded that, in the circumstances of this particular case, the imposition of stringent conditions would better protect patients, uphold proper standards of conduct, and satisfy the need for public confidence in the profession. The Committee accepts the submissions of the GOC in this regard.

98. The requisite conditions are attached to this Decision.

99. The Committee considered that there should be a review of the conditional order before it expires. The review should take place within 12 months of the order taking effect. At that stage, any future Committee will need to be reassured that the Registrant is fit to resume practice, either unrestricted or with conditions or further conditions. Where conditions have been imposed, the Registrant must demonstrate to the Committee that he has satisfied the conditions imposed at this hearing.

Immediate order

100. The Committee has heard submissions from Mr Lawson and from the Registrant. It has accepted the advice of the Legal Adviser.

101. The Committee has decided to impose an immediate conditions order for the following reasons, namely to ensure that an order is in place during the period where an appeal could be lodged.

Chair of the Committee: Ian Crookall

Signature …  … Date: 13 September 2022

Registrant: Michael Moon

Signature …Mr Moon attended via remote hearing… Date: 13 September 2022

List of conditions

A1	**Standard conditions**
A1.1 Informing others	You must inform the following parties that your registration is subject to conditions. You should do this within two weeks of the date this order takes effect. a. Any organisation or person employing or contracting with you to provide paid or unpaid optical services, whether or not in the UK (to include any locum agency). b. Any prospective employer or contractor where you have applied to provide optical services, whether or not in the UK. c. The Chair of the Local Optometric Committee for the area where you provide optometric services. d. The NHS body in whose ophthalmic performer or contractor list you are included or are seeking inclusion.
A1.2 Employment and work	You must inform the GOC within two weeks if: a. You accept any paid or unpaid employment or contract, whether or not in the UK, to provide optical services. b. You apply for any paid or unpaid employment or contract to provide optical services outside the UK. c. You cease working. This information must include the contact details of your prospective employer/ contractor and (if the role includes providing NHS ophthalmic services) the relevant NHS body.

A1.3 Supervision of Conditions	You must: a. Identify a supervisor who is a registered optometrist who is not related to you who would be prepared to monitor your compliance with the conditions A.1.4 (i) (ii) and (v) set out below b. Ask the GOC to approve your supervisor within 2 weeks of the date this order takes effect. If you are not employed, you must ask us to approve your workplace supervisor before you start work. c. Identify another supervisor if the GOC does not agree to your being monitored by the proposed supervisor. d. Place yourself under the supervision of the approved supervisor and remain under their supervision for the duration of these conditions. e. Arrange for your supervisor to review 10 randomly selected patient records within 3 months of these conditions taking effect and thereafter at 3 monthly intervals until the first review of these conditions. f. At least once every 3 months meet your supervisor to review compliance with your conditions and your progress with any personal development plan, focusing on the following areas; i) demonstrate how you have ensured that your clinical records accord with the standards expected of a GOC registered Optometrist. ii) demonstrate how you have adapted your practice to ensure that your clinical assessments of patients accord with the standards expected of a GOC registered Optometrist. iii) demonstrate how you have developed your approach and skills to interact with patients and colleagues in a professional environment. g. Within 14 days of the meetings referred to at f. above and at least 1 month before each review hearing or upon request by the GOC, submit a written report from your supervisor to the GOC, detailing how you have complied with the conditions which the supervisor is monitoring.

	h. Develop a structured system to enable patients to give you feedback on their experience of being treated by you and to take action to address any issues which may arise. i. Formulate a personal development plan, including proposals for training, which should be specifically designed to address deficiencies in those areas of your practice identified by the Committee, in particular your record keeping, your assessment of patients and your interaction with patients. j. Arrange to submit your personal development plan to the GOC for the first review hearing details and examples of how you have complied with conditions in f above. k. Inform the GOC of any proposed change to your supervisor and again place yourself under the supervision of someone who has been agreed by the GOC.
A1.4 Other Proceedings	You must inform the GOC within two weeks if you become aware of any criminal investigation or disciplinary investigation against you.
A1.5 Registration Requirements	You must continue to comply with all legal and professional requirements of registration with the GOC. A review hearing will be arranged at the earliest opportunity if you fail to: a. Fulfil all CET requirements; or b. Renew your registration annually. c. At least [number of weeks] before the next review hearing, provide the GOC with a written report from the independent assessor, setting out their views on the quality of the records he reviewed.

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.