BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL

GENERAL OPTICAL COUNCIL

F(21)31

AND

MARY DOCHERTY (01-14899)

DETERMINATION OF A SUBSTANTIVE HEARING
AGREED PANEL DISPOSAL (ADP)
30 MAY 2022

Committee Members:	Sara Fenoughty (Chair) Nigel Pilkington (Lay) Victoria Smith (Lay) Catherine Collin (Optometrist) David Cartwright (Optometrist)
Legal adviser:	Margaret Obi
GOC Presenting Officer:	Tope Adeyemi
Registrant:	Present and represented
Registrant representative:	Rebecca Chalkley
Hearings Officer:	Terence Yates
Facts found proved:	Particulars 1-24 of the Allegation in their entirety
Facts not found proved:	Not Applicable
Misconduct:	Misconduct Found
Impairment:	Current Impairment Found
Sanction:	12 months Suspension with a Review
Immediate order:	Not Applicable

ALLEGATION

The Council alleges that in relation to you, Mary Elizabeth Docherty (01-14899), a registered Optometrist:

1. On or around 20 March 2015, you failed to conduct an appropriate examination of Patient 1's eyes in that you:
    a. Failed to maintain adequate records in that you did not record:
        i. whether Patient 1 was new to the practice;
        ii. whether you reviewed Patient 1's previous records;
        iii. The automated visual fields;
    b. Did not obtain relevant information relating to Patient 1's history of migraines;
    c. Incorrectly recorded 'none' in the 'Ocular History' despite Patient 1 wearing glasses for distance vision tasks;
    d. Failed to perform an external ocular examination;
    e. Failed to identify and/or record that the right disc margin was indistinct;
    f. Failed to establish if a relative afferent pupil defect (RAPD) was present or not;
    g. Failed to perform a dilated fundus examination;
    h. Inappropriately placed Patient 1 on a 2-year recall despite presenting with abnormal fundus findings; and/or
    i. Failed to investigate Patient 1's abnormal fundus findings;
    j. Failed to appropriately refer Patient 1 for further investigation;

2. On or around 14 March 2011, you failed to conduct an appropriate examination of Patient 2's eyes in that you:
    a. Failed to obtain and/or record relevant history relating to the nature of Patient 2's headaches;
    b. Failed to record detailed clinical notes;
    c. Failed to perform and/or record an external eye examination; and/or
    d. Failed to adequately record the results of the visual field plot in the main record;

3. On or around 7 May 2013, you failed to conduct an appropriate examinations of Patient 2's eyes in that you:
    a. Failed to obtain and/or record relevant history relating to the nature of Patient 2's headaches;
    b. Failed to record detailed clinical notes;
    c. Failed to perform and/or record an external eye examination;
    d. Inappropriately placed Patient 2 on a 2-year recall, despite Patient 2 presenting with unilateral optic nerve head swelling in the right eye;
    e. Failed to investigate Patient 2's presenting condition of unilateral optic nerve head swelling in the right eye; and/or
    f. Failed to appropriately refer Patient 2 for further investigation despite presenting with symptoms of swollen optic disc and/or potential papilloedema;

4. On or around 5 October 2013, you failed to conduct appropriate examinations of Patient 4's eyes in that you:
    a. Failed to obtain and/or adequately record relevant history and/or symptoms;
    b. Failed to adequately record what 'clear' relates to under the ocular examination;
    c. Failed to record the duration, laterality or associated symptoms of Patient 4's reduced near vision;
    d. Failed to adequately record the presence of abnormalities in the fundus photos;
    e. Failed to recognise the presence and significance of central lesions on the posterior pole;
    f. Failed to adequately record the presence of central lesions on the posterior pole; and/or
    g. Failed to appropriately refer Patient 4 for further investigation;

5. On or around 20 June 2015, you failed to conduct appropriate examinations of Patient 4's eyes in that you:
    a. Failed to obtain and/or adequately record relevant history and/or symptoms;
    b. Failed to adequately record what 'clear' relates to under the ocular examination;
    c. Failed to record the duration, laterality or associated symptoms of Patient 4's reduced near vision;
    d. Failed to perform and/or record an internal ocular examination;

e. Failed to adequately record the presence of abnormalities in the fundus photos;

f. Failed to record fundus examination;

g. Failed to recognise the presence and significance of central lesions on the posterior pole;

h. Failed to record the significance that the lesions were enlarging and becoming worse suggesting an active inflammatory process;

i. Failed to adequately record the presence of central lesions on the posterior pole; and/or

6. On or around 10 October 2015, you failed to conduct appropriate examinations of Patient 4's eyes in that you:

a. Failed to ascertain the basis of Patient 4's headaches and ocular pain;

b. Failed to adequately record the presence of abnormalities in the fundus photos;

c. Failed to record the significance that the lesions were enlarging and becoming worse suggesting an active inflammatory process;

d. Failed to recognise the presence and significance of central lesions on the posterior pole;

e. Failed to adequately record the presence of central lesions on the posterior pole; and/or

f. Failed to appropriately refer Patient 4 for further investigation;

7. On several occasions between 22 September 2010 and 30 December 2016, you failed to conduct appropriate examinations of Patient 6's eyes in that you:

a. On or around 22 September 2010, you:

i. Failed to obtain and/or adequately record detailed history and symptoms of Patient 6's reduced vision, headaches and previous eye infection;

ii. Did not offer a dilated fundus examination;

iii. Failed to record a reason for not offering a dilated fundus examination;

iv. Failed to perform automated visual fields test; and/or

v. Failed to perform binocular vision, pupils, or motility assessments;

b. On or around 7 September 2011, you:

i. Failed to obtain and/or adequately record detailed history and symptoms of Patient 6's reduced vision, headaches and previous eye infection;

ii. Did not offer a dilated fundus examination;

iii. Failed to record a reason for not offering a dilated fundus examination;

iv. Failed to perform an assessment of the anterior eye by slit lamp bimicroscopy;

v. Failed to perform a cover test;

vi. Failed to record clear results of the fundus findings;

vii. Failed to record the presence of a central visual field deficit;

c. On or around 9 May 2012, you:

i. Failed to record detailed history and symptoms of Patient 6's sore, watery, blurry right eye;

ii. Failed to investigate Patient 6's presenting complaint of sore, watery, blurry right eye;

iii. Failed to record an internal ocular examination;

iv. Failed to record an external ocular examination;

v. Inappropriately advised Patient 6 to update her spectacles;

vi. Failed to record clinical findings of cataracts;

d. On or around 5 September 2012, you:

i. Failed to record the slit lamp findings;

ii. Failed to perform a dilated eye examination;

iii. Failed to adequately perform the primary eye examination;

iv. Failed to record clear and detailed notes about why Patient 6 was urgently referred;

v. Failed to identify and/or urgently refer for symptoms of uveitis;

e. On several occasions between 5 October 2015 until 30 December 2016, you:

i. Failed to record the presence of chronic severe anterior uveitis in both eyes;

ii. Incorrectly prescribed new spectacles;

iii. Incorrectly describe the pupils as 'PERLA' despite ophthalmology describing the right pupil as 'stuck down' with '360 posterior synechaie' and the left eye demonstrating traumatic mydriasis after a fall;

iv. Failed to accurately test the pupil reactions;

v. Failed to record Patient 6's ophthalmology visits;

8. On or around 26 July 2013 you failed to conduct appropriate examinations of Patient 7's eyes in that you:
    a. Failed to record clear detailed clinical notes;
    b. Failed to perform and/or adequately record the internal and external ocular examinations;
    c. On 5 August 2013, 1 December 2014, 24 February 2016 and 15 and 24 August 2016, you failed to measure anterior chamber angle or depth, despite this being a standard procedure as laid out in SIGN 144;
    d. On 3 and 17 August 2015 and 15 and 24 August 2016, you failed to urgently refer Patient 7 for further investigation despite the patient presenting with high intraocular pressure (IOP);
    e. On 15 and 24 August 2016, you incorrectly describe the fundus as 'clear' despite guidance within SIGN 144 (March 2015), relating to the examination and recording of findings relating to the optic nerve in patients at risk of glaucoma;

9. On several occasions between 24 October 2010 and 23 August 2016, you failed to conduct appropriate examinations of Patient 8's eyes in that you:
    a. Failed to obtain and/or record detailed history and symptoms regarding Patient 8's reason for visit prior to cataract surgery;
    b. Failed to record clear detailed notes for the internal and external ocular examination;
    c. Failed to carry out automated visual fields in the presence of elevated IOP;
    d. Failed to recognise the significance of Patient 8's increased IOP;
    e. Failed to perform an assessment of anterior chamber depth in the presence of increased IOP;
    f. Failed to record the extensive peripapillary atrophy suggestive of myopia prior to cataract surgery, despite this being clinically indicated in the fundus images;
    g. Inappropriately and/or incorrectly advised Patient 8 to update their glasses despite presenting with increased IOP;
    h. Failed to give Patient 8 information about the treatment options available regarding their increased IOP;
    i. Inappropriately placed Patient 8 on a 24-month recall despite presenting with increased IOP;

j. Failed to investigate or appropriately refer Patient 8 despite presenting with increased IOP in both eyes;

k. Failed to recognise Patient 8's potential risk for glaucoma; and/or

l. Failed to refer Patient A;

10. On several occasions between 20 September 2012 and 13 January 2017, you failed to conduct appropriate examinations of Patient 9's eyes in that you:

a. Failed to record detailed notes for the internal ocular examination at each visit;

b. On 20 and 25 September 2012, you failed to record detailed notes of the anterior eye examination;

c. On 7 May 2013, you did not record any comments in relation to the inconsistent field plots;

d. On 9 October 2013, you:

i. Failed to perform visual fields;

ii. Failed to record clear detailed notes for the ocular examinations;

e. On 29 October 2014, you incorrectly recorded the cataract surgery as being done in 2012 despite previously being noted as 2008;

f. On 6 October 2015, you:

i. Failed detect the presence of Pseudoexfoliation;

ii. Failed recognise Patient 9's risk of glaucoma;

g. Between 1 March 2016 and 13 January 2017, you:

i. Performed only two internal ocular examinations out of five separate occasions;

ii. Inappropriately and/or incorrectly prescribed new glasses at four visits;

h. Failed to record and/or maintain consistent clinical notes;

11. On several occasions between 1 May 2010 and 5 January 2015, you failed to conduct appropriate examinations of Patient 14's eyes in that you:

a. From 1 May 2010 to 7 March 2014, you:

i. Failed to record detailed clinical notes;

ii. Failed to maintain the minimum data set requirement for GOS;

b. On or around 22 April 2014, you:

i. Failed to offer dilation to Patient 14;

ii. Failed to perform visual fields;

iii. Failed to conduct an assessment of the pupils;

iv. Failed to record how the fundus was examined;

c. On or around 13 December 2014, you:

i. Recorded results of an internal ocular examination that were contrary to the presenting symptoms;

ii. Failed to offer dilation to Patient 14;

iii. Failed to assess the pupils or IOPs;

iv. Failed to record the reason for Patient 14's 'vulnerability';

v. Failed to record advice for flashes and floaters;

d. On or around 6 January 2015, you:

i. Recorded results of an internal ocular examination that were contrary to the presenting symptoms;

ii. Failed to perform a dilated fundus examination;

iii. Failed to conduct an assessment of the pupils; Failed to perform visual field tests; and/or

iv. Failed to appropriately refer Patient 14 for further investigation;

12. Between 16 July 2010 and 21 December 2016, you failed to conduct appropriate examinations of Patient 19's eyes in that you:

a. On or around 7 December 2016, you:

i. Failed to record details of any action taken following trauma to Patient 19's left eye;

ii. Failed to record legible notes of the internal and external examinations;

iii. Inappropriately and/or incorrectly advised new glasses;

iv. Failed to appropriately investigate the presenting symptoms;

v. Failed to refer for medical opinion;

b. On or around 21 December 2016, you:

i. Failed to perform automated visual fields;

ii. Failed to assess the colour vision;

iii. Failed to assess the pupils including RAPD;

iv. Failed to adequately assess any aspect of optic nerve function;

v. Failed to perform an anterior eye examination;

vi. Did not offer a dilated fundus examination;

vii. Failed to appropriately investigate the presenting symptoms;

viii. Failed to refer for medical opinion;

13. On several occasions between 7 July 2012 and 2 February 2017, you failed to conduct appropriate examinations of Patient 23's eyes in that you:

a. On or around 7 July 2012, you:

i. Failed to record detailed ocular examination;

ii. Failed to record visual acuity;

iii. Failed to adequately investigate the presenting symptoms;

b. On or around 30 August 2013, you:

i. Failed to perform and/or record the cycloplegic examination;

ii. Failed to advise on the reason for dispensing glasses, what changes to expect, or if it is full or part time wear;

c. On or around 12 November 2013, you:

i. Failed to record the visual acuity;

ii. Failed to record why the patient wears glasses;

iii. Failed to perform an internal ocular examination;

iv. Failed to perform an external ocular examination; and/or

v. Failed to consider the cycloplegic results from the previous examination;

d. On or around 2 April 2014, you:

i. Failed to perform an internal ocular examination;

ii. Failed to perform an external ocular examination;

e. On or around 6 October 2014, you:

i. Did not offer a cycloplegic examination;

ii. Failed to record a reason why cycloplegic examination is not offered;

f. On or around 3 December 2015, you:

i. Did not offer a cycloplegic examination;

ii. Failed to record a reason why cycloplegic examination is not offered;

iii. Failed to investigate the reduction in visual acuity;

f. Failed to accurately record results of refraction;

g. Failed to record the method being used to record vision;

14. On several occasions between 21 December 2012 and 26 October 2016, you failed to conduct appropriate examinations of Patient 24's eyes in that you:

    a. On or around 21 December 2012, you did not use an age-appropriate test to measure visual acuity;

    b. On or around 24 June 2013, you:

        i. Failed to record visual acuity;

        ii. Failed to perform an internal ocular examination;

        iii. Failed to perform an external ocular examination;

    c. On or around 6 September 2013, you:

        i. Failed to perform visual acuity;

        ii. Failed to perform an internal fundus examination;

        iii. Failed to perform an external fundus examination;

    d. On or around 29 January 2014, you:

        i. Failed to record visual acuity;

        ii. Failed to perform an internal fundus examination;

        iii. Failed to perform an external fundus examination;

    e. On or around 6 February 2015, you:

        i. Failed to record visual acuity with previous or new prescription;

        ii. Failed to record detailed notes for internal ocular examination;

        iii. Failed to record detailed notes for external ocular examination;

    f. On or around 13 November 2015, you:

        i. Failed to clearly record the visual acuity;

        ii. Failed to perform an internal fundus examination;

        iii. Failed to perform an external fundus examination;

    g. On or around 28 April 2016, you:

        i. Failed to record how the visual acuity result was achieved;

        ii. Failed to perform internal ocular examination;

        iii. Failed to perform external ocular examination;

        iv. Failed to perform ocular motility test;

        v. Failed to perform cover test;

        vi. Failed to conduct a pupil assessment;

        vii. Failed to record a recall period;

h. On or around 13 September 2016, you:

i. Failed to perform an internal fundus examination;

ii. Failed to perform an external fundus examination;

i. Failed to understand what tests should be conducted as age appropriate when measuring visual acuity in children of a young age;

j. Failed to record the method of measuring visual acuity at any stage of the tests;

k. Performed cycloplegic refraction only once out of the nine visits;

l. Failed to appropriately refer Patient 24 for further investigation based on poor visual acuity and failure to obtain a standard of vision comparable to peers;

15. On several occasions between 6 September 2013 and 27 November 2016, you failed to conduct appropriate examinations of Patient 30's eyes in that you:

a. Failed to record clear detailed notes on the reason for the visit;

b. On or around 1 September 2014, you:

i. Failed to perform automated visual fields;

ii. Failed to obtain and/or record information in relation to Patient 30's ocular or general health;

iii. Failed to appropriately investigate the vascular changes;

iv. Failed to appropriately refer for medical opinion;

v. Failed to appropriately advise Patient 30 to seek advice from their GP in relation to cardiovascular causes;

vi. Failed to recognise the potential significance of 'scattered exudate' across the right fundus;

16. On several occasions between 26 August 2013 and 13 August 2014, you failed to conduct appropriate examination of Patient 32's eyes in that you:

a. On or around 26 August 2013, you:

i. Failed to clearly record what method was used to record the vision;

ii. Failed to identify and/or appropriately refer for symptoms of amblyopia;

b. On or around 9 December 2013, you:

i. Failed to record the visual acuity;

ii. Inappropriately and/or incorrectly prescribed new spectacles;

c. On or around 1 April 2014, you failed to refer Patient 32 for further investigation;

d. On or around 13 August 2014, you:

i. Failed to record the stereoacuity;

ii. Failed to record internal ocular examination;

iii. Failed to appropriately refer Patient 32 for further investigation;

iv. Failed to appropriately advise Patient 32's parent of treatment options available for esotropia;

17. On several occasions, between 2 July 2010 and 27 May 2016, you failed to conduct appropriate examination of Patient 33's eyes in that you:

a. Incorrectly identified cataracts as the reason for Patient 33's reduced vision in right eye;

b. Failed to advise Patient 33 that the vision in their right eye is unlikely to improve;

c. Failed to record legible notes;

18. On several occasions, between 17 November 2012 and 31 March 2016, you failed to conduct appropriate examinations of Patient 42's eyes in that you:

a. On or around 17 November 2012, you:

i. Failed to record the measurement of the cover test;

ii. Failed to record the visual acuity;

iii. Failed to record the subjective refraction;

iv. Failed to identify and/or appropriately refer symptoms of anisometropia;

v. Incorrectly placed Patient 42 on a 12-month recall;

b. On or around 6 September 2013, you:

i. Failed to dispense the prescription given by the HES;

ii. Gave the parent contrary advice to that of the HES about refraction;

iii. Did not use an age-appropriate test to measure visual acuity;

iv. Did not liaise with the persons within the HES who issued the prescription;

c. On or around 7 February 2014, you:

i. Failed to record the history and symptoms in reference to the previous visit in September 2013;

ii. Failed to record any subsequent HES advice;

iii. Did not offer cycloplegic refraction;

iv. Failed to record reason why cycloplegic refraction was not offered;

v. Failed to record detailed internal ocular examination;

vi. Failed to record detailed external ocular examination;

vii. Failed to identify and/or appropriately refer for symptoms of anisometropia;

viii. Incorrectly placed Patient 42 on a 12-month recall;

d. On or around 10 March 2015, you failed to record legible notes for the history and symptoms;

e. On or around 15 September 2015, you:

i. Failed to perform internal fundus examination;

ii. Failed to perform external fundus examination;

iii. Failed to recognise the significance of the reduction in visual acuity;

iv. Failed to appropriately refer Patient 42 for further investigation;

f. Failed to recognise the potential for over estimation of the visual acuity by using the Sheridan Gardiner test;

g. Did not consult with the HES and/or a multidisciplinary team prior to issuing contradictory advice about refraction, despite Patient 42 being at a higher risk of amblyopia due to their low birth weight and prematurity;

19. On several occasions, between 21 June 2010 and 15 January 2016, you failed to conduct appropriate examinations of Patient 49's eyes in that you:

a. On or around 21 June 2010, you failed to perform an external eye examination;

b. On or around 6 July 2011, you:

i. Inappropriately and/or incorrectly recorded the fundus examination as 'clear' despite it being clinically indicated that Patient 49 had a central defect in the left eye and overall reduction in hill of vision in both eyes;

ii. Inappropriately and/or incorrectly prescribed new glasses;

iii. Failed to appropriately refer Patient 49 for further investigation;

c. On or around 5 December 2011, you:

i. Told Patient 49 that – 'cataracts look about the same as last time' – or words to that effect, despite noting on the record card – 'cataract is getting worse';

ii. Your conduct at 19. c. i is misleading;

d. On or around 13 June 2012, you:

i. Failed to question Patient 49 regarding onset photopsia, duration or laterality;

ii. Inappropriately and/or incorrectly recorded the internal eye as 'clear' and fundus examination as 'clear' despite it being

clinically indicated that Patient 49 had superior loss of vision in the right eye and central loss in the left eye;

iii. Failed to appropriately advise Patient 49 of flashes and floaters or driving and vision;

iv. Failed to appropriately refer Patient 49 for further investigation;

e. On or around 10 July 2012, you:

i. Failed to recognise the significance of the Dicon field results which clinically indicated a more advanced superior defect in the right eye and a similar field in the left eye;

ii. Failed to appropriately refer Patient 49 for further investigation;

f. On or around 29 September 2012, you:

i. Failed to perform an external fundus examination;

ii. Failed to perform an internal fundus examination;

g. On or around 19 November 2012, you:

i. Failed to adequately inform Patient 49 of a significant change in prescription following cataract surgery;

ii. Failed to adequately record notes that would indicate a significant change in prescription following cataract surgery;

iii. Failed to adequately record your reasons when referring to a 'remnant of cataract extraction';

h. On or around 27 August 2013, you:

i. Failed to offer dilation;

ii. Failed to record a detailed ocular examination;

iii. Failed to perform automated fields;

i. On or around 13 January 2014, you:

i. Failed to perform YAG capsulotomy;

ii. Failed to offer dilation;

iii. Failed to address the presenting complaint;

iv. Inappropriately advised Patient 49 to 'leave at present' despite the patient complaining that 'everything is blurred in the right eye';

j. On or around 19 August 2014, you:

i. Failed to record laterality;

ii. incorrectly recorded 'Had both cataract done and laser tx' despite this being contradictory to the previously recorded detail;

iii. Failed to adequately record the ocular examination;

iv. Inappropriately and/or incorrectly prescribed new glasses despite refraction being unchanged;

v. Your conduct at 19. j. ii is misleading;

k. On or around 12 June 2015, you:

i. Failed to adequately investigate the presenting symptoms of headaches at the temples;

ii. Inappropriately and/or incorrectly recorded 'hazy' on the right media of the fundus examination, despite previous YAG capsulotomy;

iii. Inappropriately and/or incorrectly prescribed new glasses despite minimal difference in refraction found over the last three visits;

l. On or around 8 August 2015, you:

i. Failed to perform visual fields;

ii. Failed to perform a pupil assessment for RAPD;

iii. Failed to measure visual acuity;

iv. Failed to urgently refer Patient 49 for a symptoms of retinal detachment;

m. On or around 15 January 2016, you failed to maintain adequate records in that you:

i. Failed to record the significance of the previous referral or what happened consequently;

ii. Failed to record your reasons for advising Patient 49 to 'use an eye bag twice daily';

iii. Failed to record the internal ocular examination on the referral;

iv. Failed to record the external ocular examination on the referral;

v. Failed to record the distance visual acuity for the left eye on the referral;

n. On several occasions between 21 June 2010 and 15 January 2016, you:

i. Inappropriately and/or incorrectly advised Patient 49 to update their glasses despite there being minimal change in the prescription;

ii. Failed to appropriately investigate the presenting symptoms at each visit;

iii. Failed to record a detailed patient history;

iv. Failed to maintain adequate records;

20. On several occasions between 16 September 2010 and 18 March 2014, you failed to conduct appropriate examinations of Patient 53's eyes in that you:

a. On or around 16 September 2010, you:

i. Failed to record a clear reason for an eye examination;

ii. Failed to perform an internal ocular examination;

iii. Failed to perform an external ocular examination;

iv. Failed to perform refraction;

v. Failed to measure the visual acuity;

vi. Failed to record sufficient detail in relation to examination;

b. On or around 3 November 2011, you:

i. Failed to appropriately undertake paediatric refraction;

ii. Failed to perform an internal ocular examination;

iii. Failed to perform an external ocular examination;

c. On or around 18 March 2014, you:

i. Failed to adequately investigate the presenting symptoms of headaches;

ii. Failed to adequately obtain full cycloplegic refraction;

iii. Failed to recognise the significance of Patient 53's vision test;

iv. Failed to record relevant detail relating to the nature of Patient 2's headaches;

v. Failed to record any follow up notes;

21. On several occasions between 4 October 2011 and 7 October 2013, you failed to conduct appropriate examinations of Patient 61's eyes in that you:

a. On or around 4 October 2011, you failed to maintain adequate records in that you:

i. Failed to record the rationale for reducing the prescription;

ii. Failed to record the vision test;

iii. Failed to record the stereoacuity;

iv. Failed to record detailed internal eye examination;

v. Failed to record detailed external eye examination;

b. On or around 3 February 2012, you:

i. Failed to perform internal ocular examination;

ii. Failed to perform external ocular examination;

iii. Failed to record visual acuity with glasses;

iv. Failed to record stereoacuity with glasses;

v. Failed to record cover test with glasses;

c. On or around 11 October 2012, you:

i. Failed to perform internal ocular examination;

ii. Failed to perform external ocular examination;

iii. Failed to record visual acuity;

iv. Failed to record stereoacuity;

v. Inappropriately and/or incorrectly set a recall period of 12-months;

d. On or around 7 October 2013, you:

i. Did not record the frequency of wear of current spectacles;

ii. Failed to record the visual acuity with current spectacles;

iii. Failed to perform external ocular examination;

iv. Failed to record what rationale was used for working distance calculations during cycloplegic refraction;

e. On several occasions between 4 October 2011 and 7 October 2013, you:

i. Failed to address the presenting symptoms of Patient 61;

ii. Failed to recognise the significance of Patient 61's lower visual acuity than that expected of a five year-old;

iii. Failed to record by which means visual acuity was measured;

iv. Failed to fully understand cycloplegic refraction;

v. Failed to appropriately refer Patient 61 for further investigation;

22. On several occasions between 16 July 2014 and 15 August 2014, you failed to conduct appropriate examinations of Patient 63's eyes in that you:

a. On or around 16 July 2014, you:

i. Failed to measure the patient's unaided vision;

ii. Failed to measure the patient's visual acuity;

iii. Failed to record the results of the cycloplegic refraction;

iv. Failed to record legible notes of the internal ocular examination;

v. Failed to address the presenting concerns;

b. On 15 August 2014, you:

i. Failed to perform and/or record any clinical examination to support referral for occlusion therapy;

ii. Failed to record what rationale was used to reduce the prescription;

iii. Failed to reference the referral in the clinical record;

iv. Failed to reference any local arrangement for management of paediatric patients;

v. Failed to address the presenting concerns;

c. Failed to have a complete understanding of cycloplegic refraction techniques;

d. Failed to have a complete understanding of paediatric ocular examinations;

e. Failed to maintain adequate records;

23. On several occasions between 14 September 2010 and 19 May 2014, you failed to conduct appropriate examinations of Patient 64's eyes in that you:

a. On or around 16 September 2010, you:

i. Failed to record legible notes for the internal ocular examination;

ii. Failed to record an external ocular examination;

iii. Failed to record the anterior chamber angle and depth;

iv. Failed to verify the IOP measurement;

v. Inappropriately recorded 'repeat IOP on collection' despite knowing you did not perform an IOP measurement;

vi. Inappropriately and/or incorrectly placed Patient 64 on a 2-year recall despite clinically indicating critically high IOP;

vii. Failed to appropriately refer Patient 64 for further investigation despite clinically indicating critically high IOP;

b. On or around 28 November 2013, you:

i. Failed to record legible notes for the internal examination;

ii. Failed to assess the anterior chamber angle or depth;

c. On or around 6 December 2013, you:

i. Failed to appropriately refer Patient 64 for further investigation despite consistently raised IOP in the left eye;

d. On or around 24 February 2014, you:

i. Failed to measure visual acuity with spectacles;

ii. Failed to record detailed notes for the ocular examination;

iii. Failed to reference the previously recorded increased IOP;

iv. Failed to consider any referral refinement process for the previously recorded increased IOP;

e. On or around 19 May 2014, you failed to record clear detailed notes for the ocular examination;

24. In September 2013, you failed to conduct appropriate examinations of Patient 66's eyes in that you:

a. On or around 25 September 2013, you:

i. Failed to address the presenting symptoms;

ii. Inappropriately and/or incorrectly prescribed Brolene eye drops;

iii. Failed to consider the active ingredients of Brolene and how this would affect the patient;

iv. Failed to identify and appropriately investigate symptoms of keratitis;

b. On or around 27 September 2013, you:

i. Incorrectly recorded ‘opaque central area’ in the left eye which should have been the right eye;

ii. Failed to record the visual acuity in the left eye;

iii. Failed to record the rationale for what you mean by ‘clear’ or ‘slightly filmy’;

iv. Failed to recognise the significance of reduction of visual acuity in Patient 66’s right eye;

v. Inappropriately and/or incorrectly advised Patient 66 to continue with Brolene eye drops;

vi. Failed to consider the active ingredients of Brolene and how this would affect the patient;

vii. Failed to appropriately investigate the presenting symptoms;

viii. Failed to appropriately advise Patient 66 of the treatment options available;

ix. Inappropriately and/or incorrectly placed Patient 66 on a 2-year recall;

And by virtue of the facts set out above, your fitness to practise is impaired by reason of misconduct and/or deficient professional performance.

CONSENSUAL PANEL DETERMINATION AGREEMENT

1. At the outset of the hearing, Ms Adeyemi, on behalf of the GOC, informed the Committee that prior to this hearing the GOC and the Registrant had reached a provisional agreement by way of an Agreed Panel Determination (APD).

2. Ms Adeyemi summarised the Agreed Panel Report and directed the Committee’s attention to some of the key paragraphs in relation to the facts, misconduct, impairment and sanction.

3. The agreement, which was put before the Committee, sets out the Registrant’s full admission to the facts alleged in the Allegation, her acceptance that her acts and omissions amount to misconduct and that her fitness to practise is currently impaired by reason of that misconduct. It is further stated in the agreement that an appropriate sanction in this case would be a suspension order for a period of 12 months with a review. The agreement was signed on by the Registrant on 27 May 2022.

4. Ms Chalkley, on behalf of the Registrant, invited the Committee to approve the Agreed Panel Report. She submitted that the Registrant has demonstrated insight as she has admitted the Allegation in its entirety and has acknowledged that her fitness to practise is impaired. Ms Chalkley drew the Committee’s attention to the

Registrant's personal circumstances, [redacted] and reflections and learning as set out in her witness statement dated 27 May 2022.

5. Ms Chalkley emphasised during her oral submissions that the Registrant has retired from practice and as stated in her undertaking has no intention of returning to practise as an optometrist and no intention of renewing her GOC registration. Ms Chalkley further submitted that the Registrant is enjoying her new career as a celebrant and as stated in her witness statement has "*not looked back since*."

DETERMINATION

6. The Committee had regard to all the documents before it and to the proposed APD signed by the Registrant as set out in Annex A below.

7. The Committee accepted the advice of the Legal Adviser. She referred the Committee to the GOC Agreed Panel Disposal Policy ("the policy") and reminded the Committee of the public interest and the overarching objective of the GOC. She referred the Committee to:

   (i) The GOC Rules regarding findings of fact;

   (ii) The relevant case law relating to misconduct;

   (iii) The key principles relating to current impairment; and

   (iv) The GOC Indicative Sanctions Guidance.

8. The Legal Adviser advised that if, at any stage in its deliberations the Committee required further clarity, the Committee should invite further submissions from the parties. In addition, she drew the Committee's attention to paragraph 8.4 of the Policy which states:

   "*If the panel's findings are in accordance with those in the agreed panel disposal report at each stage, it will make an order setting out the reasons for its findings. If the panel wish to vary the sanction they will invite submissions from both parties… If both parties agree the variation the case will be concluded on that basis. Otherwise, the case will go to a further hearing where both parties may make new submissions."*

Facts

9. The Committee noted that the Registrant has admitted the Allegation in its entirety and is legally represented. The Committee concluded that Ms Docherty's admissions were voluntary, informed (as they followed disclosure of Allegations and the supporting evidence) and unequivocal.

10. Therefore, Ms Docherty's admissions were accepted by the Committee and found proved by reason of those admissions.

11. In reaching this conclusion the Committee noted the content of the expert report prepared by Ms Pamela Robertson, dated 22 April 2021, and was satisfied that the Allegation was capable of being found proved even if no admissions had been made by the Registrant as the evidence strongly supports findings that her acts and omissions demonstrate wide ranging clinical issues and patient safety concerns, some of which potentially resulted in harm. These included papilloedema, uveitis, glaucoma, the management of paediatric patients, multiple incidents of patients receiving refraction without ocular examination, and poor prescribing habits.

Misconduct

12. The Committee, whilst acknowledging the agreement between the GOC and the Registrant and her admissions, nevertheless exercised its own independent judgement in reaching its decision on misconduct. The Committee was mindful that it was not bound by the proposed APD.

13. The Committee noted that the Registrant 's acts and omissions are wide-ranging in nature and relate to core skills which are fundamental to safe and effective practice as an optometrist. The factual findings demonstrate that for a prolonged period of 6 years the Registrant failed to provide the high standard of clinical care that her patients were entitled to expect. The Committee noted that the export report of Ms Robertson concluded that:

"…*the standard of care by the registrant towards their patients has fallen below the standard of that of a reasonably competent optometrist on several occasions. It highlights areas where there is significant need for remedial learning and revision including (but not limited to) management of paediatric refraction, uveitis, ocular hypertension, risk factors for glaucoma, retinal vascular disease, macular degeneration, post cataract assessment, management of flashes and floaters and record keeping."*

14. The Committee noted that the APD states that a number of the paragraphs of the previous GOC Code of Conduct for Individual Registrants ('Code of Conduct') and the current GOC Standards of Practice for Optometrists and Dispensing Opticians ('the Standards') have been breached. The Committee, having reviewed these paragraphs, was satisfied that Ms Docherty's acts and omissions demonstrated a significant departure from the Code of Conduct and the Standards. The Registrant breached the following paragraphs in the Code of Conduct:

    1. *Make the care of the patient your first and continuing concern;*

5. *Give patient's information in a way they can understand and make them aware of the options available;*

6. *Maintain adequate patients' records;*

9. *Keep professional knowledge and skills up to date;*

10. *Recognise, and act within, the limits of your professional competence;*

15. *Never abuse your professional position;*

16. *Work with colleagues in the ways that best serve patients' interests;*

She also breached the following Standards:

1. Listen to patients and make sure they are at the heart of the decisions made about their care

2. Communicate effectively with your patients

5. Keep your knowledge and skills up to date

6. Recognise, and work within, your limits of competence

7. Conduct appropriate assessments, examinations, treatments, and referrals

15. The Committee concluded that the Registrant's conduct and behaviour fell far short of the standards expected of her for a significant period of time and is sufficiently serious to be characterised as misconduct.

Impairment

16. The Committee acknowledged that the Registrant has demonstrated some insight, in that she has admitted the Allegations in their entirety and accepts that her fitness to practice as an optometrist is impaired. The Committee also noted that the Registrant has apologised for acts and omissions and has expressed remorse. However, there was only limited evidence before the Committee that the Registrant fully appreciates the significance of her clinical failings and the impact of these shortcomings on her patients, the wider profession and trust and confidence of the public. The Registrant's witness statement primarily focused on her personal circumstances and her change of career. It is within this context that the Committee concluded that the Registrant's acknowledgement of fault lacked depth and detailed analysis as to what she had learned from the experience. In these circumstances, the Committee concluded that the Registrant has demonstrated only limited insight.

17. The Committee noted that the Registrant currently has no intention of returning to practise as an optometrist. However, the Committee was mindful that she could change her mind in the future. As it stands, despite the Registrant's initial willingness at the interim hearing to provide a personal development plan, since the interim order of conditions came into effect, she has undertaken no remediation, nor has she undertaken any activities which would lead to an improvement in her clinical skills. The Committee concluded that the Registrant exposed patients to the risk of harm, brought the profession into disrepute, and breached fundamental tenets of the profession. All of these features undermine the fundamental role of a registered optometrist. Although the Registrant had indicated that she has no intention of returning to the profession, in the absence of evidence of sufficient insight and meaningful reflection the Committee determined that there is a current and ongoing risk of harm to patients.

18. The Committee concluded that, for these reasons, the Registrant's ability to practise safely and effectively is currently impaired.

19. In considering the wider public interest the Committee had regard to the important public policy issues which include the need to maintain confidence in the profession and declare and uphold proper standards of conduct and behaviour.

20. In the Committee's view, the Registrant's persistent clinical failings demonstrated a disregard for her professional obligations. Well-informed members of the public would be extremely concerned to learn that a registered optometrist had put her patients at risk of harm due to a wide range of failings for a long period of time. The public would be particularly concerned that these failings have not been remediated. The Registrant's conduct fell far below the standard expected and the Committee concluded that public confidence would be undermined if a finding of fitness to practise was not made, given the seriousness of the Registrant's conduct and behaviour.

21. Therefore, the Committee also concluded that the Registrant's fitness to practice is impaired based on the wider public interest.

Sanction

22. The Committee noted the APD recommends a 12-month Suspension Order with a review but with no immediate order. The Committee is not bound by that recommendation.

23. The Committee considered the sanctions available in ascending order starting with the least restrictive severe option. The Committee was aware that the purpose of sanction is to protect the public and uphold the public interest, and that any sanction must be proportionate. The Committee took into account the legal advice,

the Hearings and Indicative Sanctions Guidance (December 2021) as well as other authorities set out in the ADP.

24. The Committee agreed with the aggravating and mitigating factors as set out in the APD. It first considered imposing no sanction or to apply a Financial Penalty Order. In light of its findings on impairment, the Committee was of the view that neither of these options would be sufficient to protect patients or the wider public interest as they would not restrict the Registrant from practising. Further, a fine would be inappropriate as the misconduct was not financially motivated, nor did it result in financial gain.

25. The Committee next considered conditional registration. The Committee was mindful of its earlier findings and that any conditions must be proportionate, workable, and realistic. The Committee noted that the Registrant's clinical failings are capable of being remediated. However, such remediation requires, amongst other things, a willingness and a commitment to address the clinical failings to ensure that the risk of repetition is reduced. There was no evidence before the Committee that the Registrant is willing to take appropriate active steps to fully remediate her misconduct. On the contrary, the Registrant has made it clear that she has embarked on a new career as a celebrant, and it would appear that she is unlikely to return to practise as an optometrist. As a consequence, there is no incentive for her to remediate the impairment of her fitness to practise. In these circumstances, the Committee had no confidence that the Registrant would comply with a Conditions Registration Order, even if suitable conditions could be formulated. Therefore, the Committee concluded that conditions would not be appropriate or workable.

26. The Committee next considered a Suspension Order. Suspension is appropriate when some or all of the following factors are apparent: Paragraph 21.29 of the Indicative Sanctions Guidance:

    a. *A serious instance of misconduct where a lesser sanction is not sufficient.*
    b. *No evidence of harmful deep-seated personality or attitudinal problems.*
    c. *No evidence of repetition of behaviour since the incident*
    d. *The committee is satisfied the registrant has insight and does not pose a significant risk of repeating behaviour*
    e. *In cases where the only issue relates to the registrant's health, there is a risk to patient safety if the registrant continued to practise, even under conditions.*

27. The Committee took the view that (a)-(d) are relevant to the Registrant's case. The Committee found that the Registrant has developed some insight as demonstrated in her response to the Allegation and her witness statement. The Committee did not consider that Ms Docherty's clinical failings demonstrate a deep-seated attitudinal issue and there is no evidence of any repetition since the date of the last

allegation. However, the Committee was unable to conclude that the risk of repetition was low as the Registrant has not taken any significant steps towards remediating her misconduct.

28. The Committee therefore agreed with the APD that a 12-month Suspension Order was an appropriate and proportionate sanction which would serve to protect the public and the wider public interest. This sanction is required to reflect the seriousness of the findings and to uphold the confidence of the public in the profession.

29. The Committee carefully considered erasure. This is a serious case involving wide ranging clinical failings in fundamental skills relevant to safe and effective practise as an optometrist which persisted for a long period of time and exposed patients to an unwarranted risk of harm. However, in light of the mitigating factors identified in the ADP, the Committee formed the view that erasure was not the only means of protecting the public and maintaining public confidence in the profession. It concluded that the Registrant's conduct was not fundamentally incompatible with registration, and that erasure would be disproportionate.

30. In all the circumstances the Committee decided that a 12-month Suspension Order was necessary and appropriate to protect the public, to mark the seriousness of the conduct, to protect the reputation of the profession, to maintain public confidence and to declare and uphold proper standards.

Review Hearing

31. A review hearing will be convened shortly before the end of the period of suspension unless an early review is sought. The Committee noted that it would not be in the interest of the public for the Registrant to return to the register unrestricted whilst her fitness to practise remains impaired. This Committee cannot bind a future reviewing committee. However, it is likely that a reviewing committee will be assisted by either:

    i. Evidence of remediation (in the event that the Registrant changes her mind about returning to practise); or

    ii. An indication of her intention at that time regarding her future GOC registration.

Revocation of the current interim order

The Committee hereby revokes the current interim order of conditions.

Chair of the Committee: Sara Fenoughty

Signature **Date: 30 May 2022**

Registrant: Ms Mary Docherty

Signature present via video **Date: 30 May 2022**

ANNEX A

Agreed Panel Disposal

Introduction

1. *This is a substantive hearing in respect of Mary Docherty ("Registrant") a registered optometrist first registered with the General Optical Council ("the Council") as an optometrist on 13 August 1993. The Fitness to Practise Committee ("FTPC") meet to consider whether to approve an agreed form of disposal under the Agreed Panel Disposal ("APD") process. Both parties agree to the proposed form of disposal set out in this report. The Registrant has had the benefit of legal advice from the Association of Optometrists ("AOP") before agreeing to dispose of this case by the APD process.*

2. *The Council's published policy on the APD process is addended to this report. It is a hearing management tool, designed to assist in avoiding full hearings with the calling of evidence where the public protection and public interest objectives of the fitness to practise process would still be met by an agreed outcome. It is not a separate statutory tool or path to a finding of impaired fitness to practise. The FTPC retains full jurisdiction over the procedure and, save where it would be otherwise appropriate not to do so, the proposed APD is considered at a public hearing. The options open to the FTPC are: i. To approve the report in its entirety and make the appropriate order(s); ii. To vary the sanction with the agreement of both parties after inviting submissions. If one or both parties disagree with the variation suggested by the FTPC, the APD hearing will be vacated and the matter will be scheduled for a*

substantive hearing before a new committee without an agreed report; iii. To disagree with all or part of the report. In this instance, the GOC and the registrant may agree to amend the report in light of the FTPC's findings and resubmit this to the same committee at a reconvened hearing, otherwise the APD hearing will be vacated and the matter will be listed for a substantive hearing before a new committee without an agreed report; iv. If either party decides that they no longer want the case to proceed by APD, the current hearing must be immediately concluded by the FTPC with no orders being made (unless there is a request for procedural directions from both parties). The matter will then be scheduled for a substantive hearing before a new committee without an agreed report.

Background

3. *The Council's case was served on the registrant on 7 December 2021.*

4. *On 19 July 2019, NHS [redacted] ("the Complainant"), informed the Council that a whistle blower had contacted them regarding the care the Registrant provided to nine patients. The Registrant was informed of this and that the General Ophthalmic Services Performance Review Group ("PRG") would be reviewing these patients' files. The PRG found concerns in 8 of the 9 cases. The PRG looked at wider sample of 60 random records and found concerns in 14 of them, identifying 'multiple incidents of inadequate patient management, some potentially resulting in long term harm'.*

   Specifically, the concerns include:

   • A wide range of clinical issues and patient safety incidents, some of which potentially resulted in harm. These incidents included, but were not limited to, papilledema, uveitis, glaucoma, and paediatric management, often with more than one isolated incident identified.

   • Multiple incidents of patients receiving refraction but no ocular examination. This does not comply with the Opticians Act 1989 requirements on the testing of sight.

   • Patients were often prescribed new spectacles at short intervals with small changes in prescription.

   • Several standards of practice in the GOC Code of Conduct have been breached.

5. *On 8 November 2019, the Registrant was made subject to an interim order of conditions for 18 months. At the hearing she made reference to a Personal Development Plan and the view of the Committee was she had taken a commendable approach to address areas of practice in which she needed additional support.*

6. *However, on 24 April 2020 at the First Interim Review hearing, the Committee was concerned about the absence of any further remediation.*

7. *On 9 July 2020, the Registrant sent an email to the Council explaining she was no longer in practice and had no intention of returning to practice.*

8. *On 25 October 2021, the Registrant was notified that the matter had been referred to the Fitness to Practise Committee.*

9. *On 7 December 2021, the Council's case was served on the Registrant.*

10. *On 17 December 2021, the FTPC continued the order of conditions.*

11. *In the Hearings Questionnaire dated 18 January 2022, the Registrant admitted to all the allegations and explained that she has retired from practise.*

12. *On 26 January 2022, the Council received confirmation from the Registrant's legal representative that the Registrant accepts she is currently impaired.*

13. *The Registrant has been invited by the Council to sign a voluntary undertaking to the effect that:*

    a) She has not practised as an optometrist since 1 August 2019;

    b) She has retired from practice;

    c) She will not apply to renew her GOC registration;

    d) She will not use any title or conduct any activity restricted to GOC registrants; and

    e) She will not seek retention on, or restoration to, the GOC register.

...

Nature of the Recommended Disposal

14. *Upon the Registrant's admissions and upon the Council and Registrant agreeing to this recommendation, the parties jointly seek and recommend to the FTPC that this matter is disposed of by a determination on the following basis:*

    i. *All of the particulars of the allegations are admitted and found proved;*

    ii. *That the particulars of the allegations amount to misconduct and/or deficient professional performance;*

iii. *That the Registrant's fitness to practise is impaired by reason of misconduct and/or deficient professional performance; and*

iv. *The appropriate and proportionate sanction is a 12-month suspension with no review.*

Law

15. *The matter is governed by The Opticians Act 1989 ("the Act") and The General Optical Council (Fitness to Practise) Rules Order of Council 2013 ("the Rules").*

16. *In accordance with Rule 46 a hearing is required to be conducted in three stages:*

    i. *Stage 1 - Findings of fact;*

    ii. *Stage 2 - Findings on whether, as a result of the facts found proved, the Registrant's fitness to practise is impaired by reason of misconduct and/or deficient professional performance;*

    iii. *Stage 3 - Consideration of the appropriate sanction, if any.*

17. *Rule 40(6) provides: "the registrant may admit a fact or description of a fact, and a fact of description of a fact so admitted may be treated as proved."*

18. *More detailed submissions are set out below in respect of each stage.*

Stage 1: Factual Findings

19. *On 19 July 2019, the Complainant informed the Council that they had received a whistleblowing concern relating to the historic standard of care provided to nine patients by the Registrant. The Complainant explained that the Registrant was made aware that a concern had been raised, and that the concern would be reviewed by the health boards PRG. This group consisted of a mixture of optometrists, ophthalmologists, and health board managers. Having reviewed the nine patient records, the PRG agreed there were some valid concerns and that further information and investigation was required. Following these additional checks, the group concluded that there were concerns in eight of the 9 cases identified. In one of these cases, the patient was also seen by her GP and A&E, as a result further investigations were conducted. As part of the investigation the PRG looked at a wider sample of sixty historic records. The additional records were picked at random and the whistle blower was not given any advance notice of which records would be looked at. Of the sixty additional records reviewed, the PRG identified significant concerns with a further 14 patient records. The PRG concluded that significant historical patient safety concerns were identified, with multiple incidents of inadequate patient management, some potentially resulting in long term harm.*

20. *The PRG agreed that the Registrant should be referred to the Council for the following reasons:*

    • Wide range of clinical issues and patient safety incidents identified during our investigation, some of which potentially resulted in harm. These incidents included but were not limited to papilloedema, uveitis, glaucoma, and paediatric management, often with more than one isolated incident identified.

    • Multiple incidents of patients receiving refraction, but no ocular examination (failing to comply with the Opticians Act 1989 requirements on the testing of sight).

    • Patients were often prescribed new spectacles at short intervals with small changes in prescription.

    • Breach of several of the standards of practice in the GOC Code of Conduct.

21. *The expert report prepared by Pamela Robertson dated 22 April 2021 states: "It is my opinion that the standard of care by the registrant towards their patients has fallen below the standard of that of a reasonably competent optometrist on many occasions. It highlights areas where there is significant need for remedial learning and revision including (but not limited to) management of paediatric refraction, uveitis, ocular hypertension, risk factors for glaucoma, retinal vascular disease, macular degeneration, post cataract assessment, management of flashes and floaters and record keeping. This case highlights poor understanding of the Opticians Act 1989 (and the requirement for fundus examination when performing a refraction / sight test) and the requirements of supplementary eye examinations, particularly that of children when reviewing under General Ophthalmic Services (Scotland) as amended." [sic] (page 538). The Registrant has accepted this opinion in her Hearings Questionnaire dated 18 January 2022.*

22. *In a witness statement provided by* [redacted] *of Primary Care for NHS [redacted], dated 15 June 2021, he states: "Mrs Docherty attended a meeting with our Primary Care Contracts Manager and Optometric Adviser on the 23 November 2018 to discuss the initial sample of patient records provided by the whistle blower. At that meeting Mrs Docherty agreed that the recording of information in the patient's records was not very good and was not the normal level of practice. Mrs Docherty advised that she was now recording patient information differently. As they discussed each record, there was a general pattern where Mrs Docherty acknowledged that better record keeping was required, further investigations should have been carried out and better advice should have been provided to the patients." [sic] (page 544)*

23. *The Registrant admits the facts alleged against her. This is confirmed in the Hearings Questionnaire dated 18 January 2022.*

Stage 2: Misconduct/Deficient Professional Performance and Impairment
Misconduct

24. *With regard to the issue of misconduct, there is no definition but a review of some of the authorities provides some guidance, Lord Clyde in Roylance v GMC (no.2) [2000] 1 A.C. 311 Lord Clyde, in his judgment at page 331, stated:*

"Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word "professional" which links the misconduct to the profession of medicine. Secondly, the misconduct is qualified by the word "serious". It is not any professional misconduct which will qualify. The professional misconduct must be serious".

25. *In the case of R (on the application of) Remedy UK v General Medical Council [2010] EWHC 1245 at paragraph 37, it way stated:*

"First, it may involve sufficiently serious misconduct in the exercise of professional practice such that it can properly be described as misconduct going to fitness to practise. Second, it can involve conduct of a morally culpable or otherwise disgraceful kind which may, and often will, occur out with the course of professional practice itself, but which brings disgrace upon the doctor and thereby prejudices the reputation of the profession."

26. *As to seriousness, Collins J, in Nandi v General Medical Council [2004] EWHC (Admin), rightly emphasised, at paragraph 31 of his judgment,*

"the need to give it proper weight, observing that in other contexts it has been referred to as 'conduct which would be regarded as deplorable by fellow practitioners'."

27. *In the case of Calhaem v General Medical Council [2007] EWHC 2606 (Admin) at paragraph 39 at paragraph (1) Jackson J (as he then was) said:*

"(1) Mere negligence does not constitute "misconduct" within the meaning of section 35C(2)(a) of the Medical Act 1983. Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to "misconduct". (

2) A single negligent act or omission is less likely to cross the threshold of "misconduct" than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single act or omission, if particularly grave, could be characterised as "misconduct".

(3) "Deficient professional performance" within the meaning of section 35C(2)(b) is conceptually separate from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low

and which (save in exceptional circumstances) has been demonstrated by reference to a fair sample of the doctor's work.

(4) A single instance of negligent treatment, unless very serious indeed, would be unlikely to constitute "deficient professional performance".

(5) It is neither necessary nor appropriate to extend the interpretation of "deficient professional performance" in order to encompass matters which constitute "misconduct"".

28. *It is agreed by both the Council and the Registrant that the Registrant's conduct breached the following paragraphs of the GOC Code of Conduct for Individual Registrants:*

1. Make the care of the patient your first and continuing concern;

5. Give patient's information in a way they can understand and make them aware of the options available;

6. Maintain adequate patients' records; 8. Keep professional knowledge and skills up to date;

9. Recognise, and act within, the limits of your professional competence;

15. Never abuse your professional position;

16. Work with colleagues in the ways that best serve patients' interests;

29. *It is agreed by both the Council and the Registrant that the Registrant's conduct breached the following paragraphs of the GOC Standards of Practice for Optometrists and Dispensing Opticians:*

1. Listen to patients and make sure they are at the heart of the decisions made about their care

2. Communicate effectively with your patients

5. Keep your knowledge and skills up to date

6. Recognise, and work within, your limits of competence

7. Conduct appropriate assessments, examinations, treatments, and referrals

8. Maintain adequate patient records

10. Work collaboratively with colleagues in the interests of patients

29. *It is agreed by both parties that the allegations amount to a serious departure from the standard of practice expected of a competent optometrist.*

30. *The parties agree that the Registrant's conduct therefore amounts to misconduct and/or deficient professional performance within the meaning of section 13D(2)(a) and (b) of the Act.*

Impairment

30. *There are a number of authorities from the High Court in appeals against decisions of the General Medical Council's Fitness to Practise Panels, where the Panel has found a doctor's fitness to practise to be impaired. These authorities discussed the way in which regulatory committees should approach impairment in this case at the second stage. They are:*

    • *Cohen v GMC [2008] EWHC 581 (Admin);*

    • *Zygmunt v GMC [2008] EWHC 2643 (Admin);*

    • *Cheatle v GMC [2009] EWHC 645 (Admin);*

    • *Yeong v GMC [2009] EWHC 1923 (Admin);*

    • *CHRE v NMC and Grant [2011] EWHC 927 (Admin)*

31. *As to the meaning of fitness to practise, in the case of Zvamunt v GMC [2008] EWHC 2643 (Admin) Mr Justice Mitting (at para 29) adopted the summary of potential causes of impairment offered by Dame Janet Smith in the Fifth Shipman Inquiry Report (2004, Paragraph 25.50). Dame Janet Smith considered that impairment would arise where a doctor:*

    a) presents a risk to patients;

    b) has brought the profession into disrepute;

    c) has breached one of the fundamental tenets of the profession;

    d) has acted in such a way that his/her integrity can no longer be relied upon.

32. *Factors (a), (b) and (c) are engaged in this case.*

33. *In Cheatle v GMC, Mr Justice Cranston said this (at paragraphs 21 - 22):*

    21. There is clear authority that in determining impairment of fitness to practise at the time of the hearing regard must be had to the way the person has acted or failed to act in the past As Sir Anthony Clarke MR put it in Meadow v General Medical Council [2006] EWCA Civ 1390 [2007] 1 QB 462: "In short, the purpose of fitness to practise proceedings is not to punish the practitioner for past misdoings but to protect the public against the acts and omissions of those who are not fit to practise. The FPP thus looks forward not back. However, in order to form a view as to the fitness of a person to practice today, it is evident that it will have to take account of the way in which the person concerned has acted or failed to act in the past".

22. "In my judgement this means that the context of the doctor's behaviour must be examined. In circumstances where there is misconduct at a particular time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and to the present time, is such as to mean that his or her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions, or maybe not at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practice Panel could conclude that, looking forward, his or her fitness to practise is not impaired, despite the misconduct".

34. *In Yeong v GMC [2009] Mr Justice Sales said (at Para 21):*

"It is a corollary of the test to be applied and of the principle that a FTPP is required to look forward rather than backward that a finding of misconduct in the past does not necessarily mean that there is impairment of fitness to practise - a point emphasised in Cohen and Zygmunt...in looking forward the FTPP is required to take account of such matters as the insight of the practitioner into the source of his misconduct, and any remedial steps which have been taken and the risk of recurrence of such misconduct. It is required to have regard to evidence about matter that have arisen since the alleged misconduct occurred".

(At Para 48): "Miss Grey submitted that each of Cohen, Meadow and Azzam was concerned with misconduct by a doctor in the form of clinical errors and incompetence. In relation to such type of misconduct, the question of remedial action taken by the doctor to address his areas of weakness may be highly relevant to the question whether his fitness to practise is currently (i.e. at the time of consideration by a FTPP) impaired; but Miss Grey submitted that the position in relation to the principal misconduct by Dr Yeong in the present case (i.e. improperly crossing the patient/doctor boundary by entering into a sexual relationship with a patient) is very different. Where a FTPP considers that the case is one where the misconduct consists of violating such a fundamental rule of the professional relationship between medical practitioner and patient and thereby undermining public confidence to the medical profession, a finding of impairment of fitness to practise may be justified on the grounds that it is necessary to reaffirm clear standards of professional conduct so as to maintain public confidence in the practitioner and in the profession, in such a case, the efforts made by the medical practitioner in question to address his behaviour for the future may carry very much less weight than in the case where the misconduct consists of clinical errors or incompetence. I accept Miss Grey's submissions that the types of cases which were considered in Cohen, Meadow and Azzam fall to be distinguished from the present case on the basis she puts forward".

35. *The High Court revisited the issue of impairment in the recent case of CHRE v NMC and Grant where Mrs Justice Cox noted (at paragraph 74):*

    "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 public in 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."

36. *Since 8 November 2019, the Registrant has been subject to an interim order for conditions and has been able to practise with restrictions. However, despite the Registrant's initial willingness at the interim hearing to provide a personal development plan, since the order came into effect she has undertaken no remediation and/or undertaken any activities to improve her clinical skills. In an email to the Council dated 9 July 2020, the Registrant explained that she was no longer in practice and had no intention of returning to practice. On 26 January 2022, the GOC received confirmation from the representative that the Registrant accepts she is currently impaired.*

37. *The Registrant accepts that her fitness to practise is currently impaired, in that:*

    i. *Her clinical skills remain inadequate to return to unrestricted practice without posing a risk to the public; and*

    ii. *It is necessary in the public interest to make a finding of impairment of fitness to practise in order to uphold professional standards and public confidence in the profession.*

Stage 3: Sanction

38. *Where the FTPC find that a registrant's fitness to practise is impaired, the powers of the FTPC are listed under section 13F (2) (3) and (4) of the Act. Section (2) states that the FTPC may, if they think fit, give a direction specified in subsection (3).*

39. *The purpose of sanctions in fitness practise proceedings are as follows:*

    a) the protection of the public;

    b) the declaring and upholding of high standards in the profession; and

    c) the maintenance of public confidence in the profession

40. *Sanctions are not intended to be punitive. Accordingly, matters of personal mitigation carry very much secondary weight. In Bolton v The Law Society [1994] 1 WLR 512 Bingham LJ said: "…the reputation of the profession is*

more important than the fortunes of any individual member. Membership of a profession brings many benefits but that is part of the price."

41. *The FTPC should have proper regard to the Indicative Sanctions Guidance unless the FTPC have sound reasons to depart from it – per Lindblom LJ in PSA v (1) HCPC (2) Doree [2017] EWCA Civ 319 at paragraph 29.*

42. *The FTPC must have regard to the principle of proportionality. The principle requires that when considering what sanction to impose in order to fulfil the statutory over-arching objective, the FTPC must take into consideration the interests of the Registrant, which may include the wider public interest in a competent optometrist being permitted to return to practice. The FTPC should consider the sanctions available, starting with the least restrictive sanction available, judging whether that sanction will be sufficient to achieve the over-arching objective, and if it will not, moving on to consider the next least restrictive sanction.*

43. *In terms of aggravating factors, the matter involves multiple record-keeping and clinical failures relating to multiple patients, both adults and children, over a prolonged period of time failures may have caused significant harm. For example, in regard to Patient 24, the expert stated: "This child was 2 years of age when they first presented to the registrant, and they were seen 9 times between December 2012 and October 2016. It is my belief that the optometrist failed to understand what tests should be conducted as age appropriate when measuring visual acuity in children of young age. At no stage is the method of recording visual acuity noted on the records, and cycloplegic refraction is carried out only once in June 2013. I have concerns that delays in referral based on poor visual acuity and failure to obtain a standard of vision comparable to peers, may result in this child suffering from amblyopia throughout their lifetime." [sic] (page 528).*

44. *In terms of mitigating circumstances, the Registrant has no previous fitness to practise history and she has shown insight by admitting the allegations and agreeing to the facts, to misconduct/deficient professional and impairment for the purposes of the fitness to practise hearing. Her agreement to the undertakings referred to, further demonstrates insight, and reduces the risks arising from her conduct due to her confirmation that she has retired will not seek to renew her registration.*

45. *Having regard to the GOC's Indicative Sanctions Guidance, the parties agree that the appropriate and proportionate sanction is 12-month suspension with review. This is to enable the Panel to reassess the registrant's position, if for any reason, we are informed the registrant wishes to return to practise.*

46. *Suspension is appropriate given the seriousness of the misconduct/deficient professional performance. Suspension is also sufficient to address the public interest concerns and to declare and uphold proper standards of conduct and behaviour and maintain confidence in the profession. Once the suspension*

is concluded the Registrant will be effectively restricted from practice on account of her undertaking.

50. *No further action, or a financial penalty order are not proportionate or sufficient given the seriousness of the misconduct/deficient professional performance.*

51. *Conditional registration is not practicable as the Registrant has no intention of returning to practice. Furthermore, conditional registration is insufficient to address the public interest concerns.*

52. *Erasure is disproportionate and excessively punitive as the registrant has had no previous adverse findings and the conduct is remediable.*

53. *The parties gave consideration to the length of the order and concluded that 12 months was the appropriate length to address the seriousness of the misconduct/deficient professional performance and the public interest concerns.*

Immediate Order

The parties do not consider it is necessary to impose an immediate order as the Registrant is no longer practising as an optometrist.

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.