PUBLIC RECORD

Dates: 19/07/2021 – 03/08/2021, 09/08/2021 – 10/08/2021, 12/08/2021

Medical Practitioner's name:	Dr Olivier REYMOND
GMC reference number:	4136437
Primary medical qualification:	MD 1993 Universite d'Aix Marseille II (Universite de la Mediterranee)

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Not Impaired

Summary of outcome

No warning

Tribunal:

Legally Qualified Chair	Ms Alice Moller
Lay Tribunal Member:	Mrs Carol-Anna Ryan-Palmer
Medical Tribunal Member:	Professor Robert Mansel

Tribunal Clerk:	Mrs Lorraine Cheetham Mr Matt O'Reilly – 02/08/2021

Attendance and Representation:

Medical Practitioner:	Present and represented
Medical Practitioner's Representative:	Mr Jonathan Caplan, QC, instructed by the MDU
GMC Representative:	Mr Peter Atherton, Counsel

Attendance of Press / Public

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

Overarching Objective

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

Determination on Facts - 30/07/2021

1. Dr Reymond qualified in 1993 from Aix Marseille University in France. Prior to the events which are the subject of the hearing, Dr Reymond moved to the UK and obtained full registration with the GMC in 1994. At the time of the events Dr Reymond was practising as a private General Practitioner in London where he has worked since October 2001. Dr Reymond is also a medical advisor to the French Consulate in London.

2. The allegation that has led to Dr Reymond's hearing is that between 2001 and 2016 Dr Reymond was Patient A's private GP and he failed to conduct and arrange an assessment of Patient A's mental capacity in 2011, or refer Patient A to a Dementia Assessment Service for assessment and management. Also that he told Ms B that Patient A had made a recovery and was able to make decisions about her finances; and wrote cheques payable to himself for Patient A to sign and received various payments. Patient A was at the time vulnerable and had not been re-assessed to confirm whether she had relevant capacity. The payments received were alleged to be excessive for the consultations recorded in the GP notes for Patient A and there were no invoices or receipts to justify some payments.

<u>The Allegation and the Doctor's Response</u>

3. The Allegation made against Dr Reymond is as follows:

That being registered under the Medical Act 1983 (as amended):

1. Between 2001 and September 2016 you were Patient A's private General Practitioner ('GP'). **Admitted and found proved**

2. From around February 2011 to January 2016 ('the Period'), you failed to:

a. conduct or arrange a formal assessment and/or re-assessment of Patient A's mental capacity; **Admitted and found proved**

b. make any reference to capacity in Patient A's GP clinical records; **Admitted and found proved**

c. refer Patient A to a Dementia Assessment Service for assessment and management. **Admitted and found proved**

3. On or around 24 November 2011 you told Ms B that 'Patient A had made a huge recovery and was now able to make decisions about her finances' or words to that effect. **Admitted and found proved**

4. During the Period, you:

a. wrote cheques for Patient A's signature which were payable to:

i. yourself; **Admitted and found proved**

ii. others; **Admitted and found proved**

b. received one or more payments from Patient A, as set out in Schedule 1 ('the Payments'). **Admitted and found proved**

5. You knew that during the Period:

a. there had been no formal re-assessment of Patient A's capacity; **Admitted and found proved**

b. Patient A was vulnerable; **Admitted and found proved**

c. Patient A's capacity to manage her financial affairs was impaired or was questionable; **To be determined**

d. you were not lawfully authorised and/or permitted to manage patient A's financial affairs; **To be determined**

e. there was a conflict of interest in respect of you managing Patient A's financial affairs whilst you were Patient A's GP; **Admitted and found proved**

f. the Payments were excessive for the consultations recorded in your GP records for Patient A; **Admitted and found proved**

g. there were no invoices and/or receipts to support and/or justify the Payments; **Admitted and found proved**

h. you were not entitled to receive the Payments; **To be determined**

i. Patient A had insufficient knowledge and/or understanding of her liability to make the Payments. **To be determined**

6. Your conduct at paragraph(s):

a. 3 was dishonest by reason of paragraph 5.a and 5.c; **To be determined**

b. 4.a. was dishonest by reason of paragraphs 5.a to 5.e; **To be determined**

c. 4.b. was dishonest by reason of paragraph 5. **To be determined**

The Admitted Facts

4. At the outset of these proceedings, Dr Reymond made admissions, through counsel Mr Caplan QC, to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the General Medical Council (GMC) (Fitness to Practise) Rules 2004, as amended ('the Rules'). In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

The Facts to be Determined

5. In light of Dr Reymond's response to the Allegation made against him, the Tribunal is required to determine whether the outstanding matters are found proved or not proved.

Witness Evidence

6. The Tribunal received evidence on behalf of the GMC from the following witnesses:

- Former Police Officer, Mr C, Single Point of Contact Vulnerable Adult Safeguarding Officer.

7. The Tribunal also received evidence on behalf of the GMC in the form of witness statements from the following witnesses who were not called to give oral evidence:

- Mr D, Senior Commissioning Manager, dated 16 November 2020;
- Ms G, Solicitor, dated 23 November 2020;
- Ms E, Personal Relationship Manager with Lloyds Banking Group, dated 27 November 2020;
- Mr F, Private Banking relationship Manager, dated, 17 February 2021;
- Mr H, Social Worker, dated, 22 April 2021.

8. Dr Reymond provided his own witness statement dated 22 June 2021 and also gave oral evidence at the hearing.

Documentary Evidence

9. The Tribunal took account of all documents provided, including, but not limited to, the following:

- Southwark Crown Court hearing Transcript, redactions agreed by counsel;
- Mr D's police statement and exhibits dated 29 December 2016 and 9 January 2017;
- Patient A's capacity assessment by Mr H dated 23 October 2015;
- Dr I's discharge report dated 21 March 2011;
- Schedule of payments;
- Cheques made payable to Dr Reymond;
- Various medical records for Patient A;
- Dr J's assessment of Patient A;
- Ms G's police statements dated, 2 October 2017 and 27 February 2018;
- Mr F's police statement, dated 6 December 2016;
- Mr C's police statements dated, 22 February 2017, 14 June 2017 and 3 May 2018;

- Social work records for Patient A RBKC;
- Patient A's Bank Statements;
- Schedule of Admissions;
- Schedule of various expenses and payments;
- Email exchange between Dr Reymond and Social Services, dated 16 March 2011;
- Expert report of Dr K, dated 25 June 2019;
- Supplemental report of Dr K, dated 18 March 2021.

Expert witness evidence

10. The Tribunal took account of evidence from Professor L, Consultant Forensic Neuro-psychiatrist with expertise in treating elderly patients. The Tribunal also received evidence from Dr K, GP, an expert witness on behalf of the GMC.

Legal advice and the Tribunal's approach

11. The Legally Qualified Chair ('LQC') gave advice in the presence of Dr Reymond and counsel; it was accepted. The LQC's advice to the Tribunal was as follows:

12. The burden of proving disputed facts is on the GMC. There is no burden on the doctor to disprove anything in the Allegation. The standard required is the civil standard, the balance of probabilities. The Tribunal will determine whether a disputed fact is more likely than not. There is no sliding scale in relation to the standard of proof, but the more serious the allegation, the more cogent the evidence may need to be to find it proved to the civil standard. Hearsay may be given less weight than direct evidence, as it will not have been tested in cross-examination.

13. Although there is no heightened standard of proof in regulatory proceedings, the inherent probability or improbability of an event is itself a matter to be taken into account in weighing the probabilities and deciding whether on balance the event occurred.

14. The Tribunal will consider the entirety of the evidence heard, in the context of documents and transcripts provided. Clear reasons should be given if the evidence of one witness is preferred over that of another in relation to a key issue in dispute.

15. A Tribunal should analyse evidence logically to reach conclusions on any inconsistencies, address counsel's main submissions and make clear its findings of fact on central disputed issues.

16. The LQC referred to the recent judgments of Mostyn LJ which are relevant to admissibility of the Transcript from Southwark Crown Court in July 2018:

- *Towuaghantse v GMC 2021 EWHC 681* at paragraphs 33-35
- *Bux v GMC 2021 EWHC 762* at paragraphs 69-77.

17. The Tribunal took account of Rule 34(1) of GMC FTP Rules 2004 which states that a Tribunal may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in court of law. Mr Caplan's submission that this evidence was relevant and fair to consider was not challenged by Mr Atherton.

18. In *Squier v GMC 2015 EWHC 299* Ousley LJ reminds Tribunals that judgments in one forum are not necessarily conclusive or even admissible, in another. A Tribunal must find for itself the facts necessary to reach a conclusion, not rely on another Court's judgment as evidence of the truth (or otherwise) of allegations.

19. Where counsel seeks to adduce a court transcript or Crown Court judgment in professional disciplinary proceedings, it is essential to ask why the document is being adduced. A verdict in the criminal court cannot be relied on to show that an allegation has, or has not, been proved on the balance of probabilities. A Judge's view of the evidence may provide relevant background or context, but it is certainly not determinative of any disputed issue before this Tribunal.

20. However, where evidence is given by witnesses in another court, this Tribunal is entitled to take account of a transcript of questions put and answers given. Counsel have both relied on evidence from the Crown Court in support of various propositions made, or to undermine assertions by their opponent. There is no objection to the Tribunal giving weight to the agreed transcript of evidence from Southwark Crown Court.

Dishonesty

21. In *R v Barton & Booth 2020 EWCA Crim 575* the Court of Appeal confirmed that the test for dishonesty is that set out in *Ivey v Genting Casinos 2017 UKSC* 67. In *Ivey* the Supreme Court provided that the correct test of dishonesty is that which is used in civil cases that:

i. The Tribunal of fact must first ascertain (subjectively) the state of the individual's knowledge or belief as to the facts. The reasonableness of the belief is a matter of evidence going to whether or not he genuinely held the belief, but it is not a requirement that the belief must be reasonable, *and*

ii. The Tribunal of fact must then consider whether that conduct was dishonest by the (objective) standards of ordinary decent people. There is no requirement that the individual must appreciate that what they have done was, by those standards, dishonest: *Ivey* at [74].

22. The Tribunal must first ascertain Dr Reymond's actual, genuine beliefs as a matter of evidence and then ask itself whether, given those beliefs, his conduct was objectively honest or dishonest.

Modified Good Character Direction to Tribunal

23. Dr Reymond is a person of good character who has no previous disciplinary matters recorded against him, except for those matters admitted and found proved in these proceedings. Good character does not provide a defence *per se*, but it is an important factor capable of assisting him. It is relevant in two ways:

First, Dr Reymond has given evidence. Good character is a positive feature of Dr Reymond which the Tribunal will take into account when considering whether or not his evidence is accepted as credible on key issues in dispute.
Second, the fact that Dr Reymond has no previous adverse regulatory findings, disciplinary matters, cautions or convictions goes to the likelihood of him now acting as alleged by the GMC. It is Dr Reymond's case that this is the first time he has been accused of the matters alleged.

24. Judging the weight to be given to Dr Reymond's good character and its relevance at the Facts stage is a matter for Tribunal, taking account of all the evidence, admissions made, law and submissions by counsel.

25. When considering dishonesty, a Tribunal is not always required to identify a benefit or motive for the making of any false statements: *Kefala v General Medical Council 2020 EWHC 2480.*

26. Mr Atherton invited the Tribunal to adopt the approach in *Cheshire West v PWK 2019 EWCOP 57* on the basis that there were parallels between the cases of PK and Patient A. This Court of Protection (COP) decision concerned a declaration by Hedley LJ that, on balance, PK lacked capacity to manage his own affairs, despite the fact that, at times, a snapshot of his condition would reveal an ability to manage his affairs.

27. The COP said that the general concept of 'managing affairs' is an ongoing act or process and, therefore, to be distinguished from a specific act, such as drafting a will or making an enduring [lasting] power of attorney. The management of affairs relates to a continuous state of affairs whose demands may be unpredictable or even urgent.

28. The declaration made established that the starting point for PK was incapacity. In PK all the relevant decision-making with which the Court was concerned lay in the field of repeat rather than isolated decisions. The psychiatrist's expert evidence was that PK lacked capacity in all relevant areas if a 'longitudinal' perspective was adopted, rather than a snapshot on a good day.

29. The Tribunal will take account of written and oral submissions by Counsel, including those on the weight to be given to evidence heard in the Crown Court. It is for the GMC to prove the Allegation on the balance of probabilities.

<u>The Tribunal's analysis of the evidence and findings of fact</u>

30. The admissibility of transcripts of evidence from Southwark Crown Court was not in dispute. A criminal charge of fraud against Dr Reymond alleged that he had abused his position as Patient A's doctor between February 2011 and January 2016 to obtain around £109,000 when he knew that she did not have the capacity to manage her financial affairs. The Allegation before this Tribunal is based on the same alleged facts. Evidence heard at Southwark Crown Court was tested in cross examination, so it can properly be given weight in

these proceedings where relevantto any issue in dispute. Most of the witnesses heard by the jury in July 2018 were not called to give evidence to this Tribunal.

31. In 2018 Dr Reymond was acquitted of fraud at Southwark Crown Court in 2018 after HHJ Bartle QC directed the jury that there was no case to answer. Several witnesses who knew Patient A and were able to observe her after her discharge from hospital in March 2011 gave evidence, including a social worker Ms B and live-in carer Ms C. Their evidence supported Dr Reymond's view that Patient A had sufficient capacity to authorise payments by cheque once settled back at home.

32. Counsel invited the Tribunal to take account of the evidence in the transcript of this trial. In addition Mr Caplan drew attention to reasons given by the Judge for accepting the defence submission of no case to answer [against Dr Reymond]. The Judge referred to evidence that Patient A regained capacity after she returned from hospital to the familiar surroundings of her own home; this came from prosecution witnesses whose evidence was not in dispute. On the basis of this 'powerful evidence' coupled with the fact that Ms B closed the case because she considered Patient A to have relevant capacity, HHJ Bartle QC found that 'any reasonable jury properly directed could only conclude that Patient A regained capacity to manage her financial affairs after her discharge from hospital [in March 2011] until 23 August 2015, when she signed her last cheque to Dr Reymond and, therefore, could not find him guilty'.

33. The Tribunal is aware that the standard of proof in the Crown Court is higher (beyond reasonable doubt, so that the jury is sure) than the civil standard used in regulatory proceedings. A criminal charge of fraud is distinct from an allegation by the GMC that a doctor's fitness to practise is impaired by reason of misconduct. This Tribunal should not adopt the reasons given by a Crown Court Judge for halting a criminal fraud trial. However all relevant evidence given by affirmed or sworn witnesses must be given weight in these proceedings; several provide useful information about Patient A's mental state at relevant times.

34. Submissions on behalf of the GMC are based on the proposition that Dr Reymond knew that Patient A lacked capacity to manage her financial affairs and that he exploited his position as friend / private GP for his own personal gain. It is alleged that he sought payments which Patient A did not understand or properly authorise. These assertions are in dispute and require to be determined.

35. After discharge from hospital on 21 March 2011, Patient A was assumed to have relevant capacity by Lloyds Bank who continued to honour signed cheques until December 2015. The bank manager's assessment included a visit to Patient A in her own flat. In July 2018 Southwark Crown Court heard evidence that Lloyds Bank was content that Patient A had capacity to authorise cheques until September 2015, when Dr Reymond requested that a power of attorney be set up as he doubted that Patient A would be able to sign cheques for much longer. The Crown Court heard unchallenged evidence that a social worker, Ms B,

concluded in January 2012 that Patient A had 'improved significantly' and recorded that 'with assistance from Dr Raymond, she has the capacity to manage her finances.'

36. Ms B assessed Patient A and concluded that she had relevant decision-making capacity; this was endorsed by supervisors in Social Services. As Professor L said in evidence to the Crown Court, social workers are able to make a valid assessment of mental capacity; it need not be a registered medical practitioner.

37. The local authority would be aware that Carewatch, a private care company, accountant/s and clinicians would bill Patient A for their professional services. In this context, Dr Reymond was advised that he or the accountant should help Patient A with an LPA. This requires the maker to have capacity to decide to make an LPA, to be utilised if/when relevant capacity is lost at some future point.

38. Evidence referred to in the Crown Court from a caretaker/cleaner Ms M indicated that Patient A was able to wash, dress independently and look after her financial affairs before she fractured her hip in February 2011. After falling at the dentist's surgery, Patient A gave a clear account of landing on her left side. On examination by Emergency Department clinicians, she was described as being 'alert and oriented' in the medical records. Five hours after the accident, Patient A remained aware of her circumstances and what had happened, suggesting that her cognition was intact. On 4 February 2011 orthopaedic surgeon Dr O wrote 'full recollection noted'.

39. Although the British National Formulary advises that a half dose of morphine be given to the elderly, because of their sensitivity to side-effects, Patient A was given the full dose of 5mg intravenously; only after absorption of this opiate is she described as confused. Oral morphine was also prescribed and could have added to her confusion, according to Professor L.

40. As he said in evidence at Southwark Crown Court, anaemia, hyponatraemia and low haemoglobin are well known to cause confusion. Patient A had a haematoma around the surgical wound post-operatively and required two pints of blood; transfusions were administered on two occasions in hospital. Ten days after surgery, signs of improvement in mental state were recorded by a hospital occupational therapist (OT). According to Professor L, this evidence casts doubt on any diagnosis of dementia.

41. Antibiotics to deal with an infection could also exacerbate confusion, as could a respiratory or urinary infection, both suspected. These recorded conditions and pharmaceutical interventions, together with Professor L's evidence about their likely impact, all support the reasonableness of Dr Reymond's opinion / belief that Patient A had delirium or acute confusional state in hospital. His evidence to the Tribunal was that he had observed this in his grandmother.

42. Despite his lack of knowledge of the Mental Capacity Act 2005 or Court of Protection procedures, Dr Reymond told the Tribunal that he had a basic understanding of mental

capacity. His scepticism about any diagnosis of dementia in 2011 arose from his perception that Patient A was able to manage finances and other activities before admission to hospital and after discharge home. In answer to Tribunal questions, Dr Reymond said that he believed Patient A could understand, retain, use and weigh relevant information to make financial decisions shortly after discharge from hospital, once she had settled home and had medication reduced.

43. Professor L's opinion was that, on admission to hospital, Patient A developed delirium on top of mild cognitive impairment. His evidence was that hospital 'medical records show multiple possible causes of delirium or confusional state, such as anaemia, constipation, haematoma, congestive heart failure, possible infection/s, morphine and Quetiapine'. Notes in hospital records indicated that Patient A's confusion was intermittent and more severe at night. Professor L said that this supports a diagnosis of delirium. He disagreed with Dr N and Dr I who missed signs of delirium, not even noting it as a differential diagnosis. Professor L cited research evidence that 66% cases of delirium are not diagnosed.

44. Professor L distinguished mild cognitive impairment (slowing down with some memory issues) from dementia. His evidence was that the diagnostic criteria for dementia require there to be a range of impairments of cognitive functioning associated with impaired ability to perform activities of daily living. It was not his opinion that mild cognitive impairment would result in a loss of capacity to make decisions about treatment or finance.

45. Evidence given by those who had regular contact with Patient A after discharge in 2011 support Dr Reymond's account that her condition improved post discharge. Over the next few years, there appears to have been a progressive deterioration in cognitive functioning that would be consistent with dementia by the end of 2015.

46. Live-in carer Ms C gave evidence to the Crown Court that Dr Reymond provided about £280 a month for food and that he provided money for other items such as clothes, sheets, slippers, bulbs; adding that Dr Reymond also gave her about £4,000 to support relatives in Nigeria, as instructed by Patient A.

47. Ms C confirmed that Dr Reymond usually came to see Patient A twice a week on Tuesdays and Fridays. Receipt books record most but not all of the cash advanced by him. Ms C saw Dr Reymond write out cheques in the presence of Patient A who would then sign them. Latterly Ms C also wrote out cheques and guided Patient A's hand to sign them.

48. The Tribunal finds as fact that, from late March 2011 to the end of March 2015 Dr Reymond advanced at least £280 a month for Patient A's living expenses, including care needs. He charged £500 a week for two clinical examinations, £250 each. A total sum of about £117,000 is comparable with sums in Ms C's receipt books and cheques to Dr Reymond of just over £119,000.

49. *Ivey* provides that the reasonableness of a belief is a factor to be taken into account when assessing whether or not it was genuinely or honestly held. Mr Caplanargued that, had

Dr Reymond sought to exploit his position for financial gain he would have agreed to take a Power of Attorney or to apply to the Court of Protection for control over Patient A's finances. An OT note made on 16/02/2011 when Patient A was in Hospital indicates that he had no desire to take control of her finances: Dr Reymond 'has reported that he does not wish to have to take on too much responsibility especially in relation to financial issues and would like some advice from Social Services.' Although unnecessary to have formal control of someone's finances to make a dishonest financial gain, the Tribunal accepted that Dr Reymond was reluctant to take responsibility for Patient A's financial affairs, as he said.

50. Dr Reymond gave evidence that he believed his words to social worker Ms B to be true, when he said that Patient A had made a 'huge recovery' and was 'now able to make decisions about her finances' or similar. He denied that it was a dishonest statement. The Tribunal accepted his evidence as it was consistent with documentary and oral evidence from others who knew Patient A or who used their specialist knowledge to provide a logical analysis of medical records. The Tribunal was not persuaded that Dr Reymond wanted Social Services out of the way so that he could make a dishonest financial gain, as submitted on behalf of the GMC.

51. Dr Reymond gave a plausible account that Patient A had made a significant recovery and had capacity to make decisions about finance. This was supported by evidence of marked improvement from those who dealt with Patient A post discharge who also believed that she had relevant capacity. In light of evidence from Professor L, Ms B and Ms C, the Tribunal considered Dr Reymond's assessment of Patient A's mental state to be reasonable as it was based on his and others' regular observations. The Tribunal finds as fact that Dr Reymond believed his opinion expressed to Ms B to be correct; it was honestly held.

52. On 26 November 2010, after falling and injuring her hand outside his surgery, Patient A asked Dr Reymond to write out a cheque for his fee of £85. As this preceded her admission to hospital with a hip fracture in 2011, it indicates a continuity in approach by Patient A to ensure discharge of liabilities, despite limited dexterity or other health issues.

53. Dr Reymond knew that Patient A was living independently prior to her fall in February 2011; she went to his surgery, as opposed to requesting home visits. Patient A had been his patient since 2001. Dr Reymond did have some concerns about her health, as reflected in a letter to Dr Pellerin dated 7 June 2010 alluding to 'slight episodes of mental confusion', adding that at other times Patient A remained 'very alert'.

54. He was aware of others' views as to how Patient A coped at home. Ms M is recorded as saying Patient A could wash, dress and manage finances prior to hospital admission in February 2011. Dr Reymond was in contact with people who knew Patient A at the French Embassy, who did not accept that she had dementia.

55. Dr Reymond was not present when Patient A left hospital with a private care worker and a friend in 2011. He told the Tribunal that he had not received a discharge summary in the post, but had a list of medication and also found a copy of the discharge summary a few

weeks later in Patient A's home. He did not recall discussing Patient A with either of the consultants who conducted a mini Mental State Examination (MSE) or capacity assessment in hospital.

56. There is no record that Dr Reymond was informed that Patient A was deemed to lack capacity to manage financial affairs when in hospital, except for a Communications Note dated 25 February 2011 saying that 'Dr Raymond patient next of kin was aware'. In cross-examination, Dr Reymond gave evidence that he had heard about a diagnosis of dementia but, like her French friends, found it difficult to believe. He believed that Patient A had delirium which would improve after discharge. Dr Reymond's account was that Patient A did improve, as he had expected, once she was back in her own home.

57. Dr Reymond's evidence to the Tribunal was that he believed that Patient A had capacity to manage finances, at the relevant times; the last (dated) cheque in Schedule 1 is dated 25 August 2015. He said that he believed Patient A had the ability to understand, retain, use or weigh information and make relevant decisions, that she authorised him to write cheques and that she was aware of their purpose. The Tribunal accepted that he believed thisand that he thought Patient A was aware of her liability to pay tax, service charges, expenses and professional fees.

Conclusions

58. The GMC has not discharged the burden on it to show that Patient A's capacity to manage her financial affairs was impaired or questionable during the relevant months. This is because it has not been shown that it was more likely than not that Patient A lacked mental capacity during that period of time to manage her financial affairs.

59. The GMC has not demonstrated to the requisite civil standard that Dr Reymond knew that he was not lawfully authorised or permitted to manage Patient A's financial affairs.

60. As the GMC has not proved that Patient A lacked capacity to make financial decisions during the relevant months, there was no need for any order from the Court of Protection or other formal authorisation for Dr Reymond to write out cheques for Patient A to sign. It was enough for Patient A to ask him to do this. Insufficient evidence has been adduced in support of the GMC case that there was a lack of (lawful) authority to manage Patient A's financial affairs.

61. Assessments of Patient A in Hospital related to decision-making capacity at the time they were undertaken, when Patient A was adversely impacted by some or all of the following: anaemia, hyponatraemia, morphine (high dose), distress/pain, Quetiapine, unfamiliar surroundings. It cannot plausibly be argued that Patient A lacked capacity to manage finances after discharge home, in light of evidence to thecontrary from the live-in carer, private GP, bank, social worker and others who regarded her as having capacity to manage financial affairs.

62. The GMC has not discharged the burden on it to prove, on the balance of probabilities, that Dr Reymond was not entitled to receive cheque payments detailed in Schedule A. It has not been shown that it was more likely than not that Patient A lacked capacity to pay for medical fees or to reimburse Dr Reymond for expenses incurred, nor that he knew or believed that Patient A lacked capacity to authorise payment or make other financial decisions. Dr Reymond's evidence that he charged for professional work undertaken was not challenged, nor did the GMC suggest that he did not incur expenses or that these should not be reimbursed.

63. No evidence was adduced by the GMC to suggest that Dr Reymond's GP visits or clinical examinations were unwarranted or not requested by Patient A. The GMC has not discharged the burden on it to show that it was more likely than not that Patient A had insufficient knowledge or understanding of her liability to make the payments made.

64. In addition, the GMC has not proved on the balance of probabilities that Dr Reymond was dishonest when he wrote cheques for Patient A to sign or when he received payments as specified. The fact that others appeared to share his view that Patient A had capacity to manage finances supports Dr Reymond's contention that his belief was reasonable. Although not conclusive as to genuineness, a reasonable belief is more likely to be honestly held than one which is not reasonable. The Tribunal finds as fact that it was reasonable to believe that Patient A had capacity to manage her financial affairs during the relevant time, that Dr Reymond believed this and that he was not dishonest in acting or speaking as he did. The Tribunal is not persuaded that objectively what Dr Reymond did, or did not do, would be regarded as dishonest in light of what he knew or believed.

65. The capacity assessments relied upon by the GMC were made at a time when Patient A was in hospital after surgery for a hip fracture. Any confusion is likely to have been caused or exacerbated by pain, intravenous and oral morphine, Quetiapine, anaemia, hyponatraemia (low sodium), haematoma, blood transfusions and any infections; the impact of all these being cumulative.

66. Neither hospital consultant, Dr I or Dr N, arranged any appointments to reassess capacity to make decisions about finance, or medical treatment, on or after discharge. Patient A was discharged with no plan to review or follow up progress. As Professor L told the Crown Court, it would have been good practice for a GP, social worker, carer, hospital clinician or accountant to arrange or facilitate at least one further assessment of mental capacity, when Patient A was able to relax in familiar home environment.

67. The assessment made in hospital could only provide a snap-shot view of mental state at the time it was undertaken. Neither assessment, by Dr I or Dr N, could provide any useful information about Patient A's ability to understand, retain, weigh or use information to make decisions about financial issues once home and no longer in pain, hyponatraemic, anaemic or affected by antipsychotic medication (Quetiapine) or high dose of morphine. No matter how thorough, a mini MSE or assessment conducted in early 2011, with numerous confounding

factors indicative of delirium, cannot be relied on as evidence for (lack of) capacity for the next four or five years.

Paragraph 5c

68. The Tribunal gave weight to the oral and written evidence of Dr Reymond, because it was supported by other documents and credible accounts of witnesses. It accepted that he was not familiar with care of the elderly as most of his patients were of working age. Although unfamiliar with the Court of Protection, he was well placed to assess Patient A's level of understanding of financial information, as her friend and private GP.

69. Dr Reymond said that after Patient A's discharge from hospital her stress levels and confusion reduced significantly. As he had anticipated, he thought that Patient A regained capacity once home. The Tribunal also took account of evidence that she raised queries about bills as indicating an ability to deal with finances.

70. As in *Cheshire West v PK 2019* the relevant decisions with which this Tribunal is concerned, such as authorising payments / signing cheques, are repeat, not isolated, decisions. However, the evidence relating to Patient A indicates that, taking a 'longitudinal' or any other view, Patient A had relevant capacity.

71. Taking account of evidence from Professor L and others, the Tribunal has concluded that Patient A was able to understand, retain and weigh information, in order to make decisions relating to financial issues during the years 2011 to 2015.

72. In order to prove that Dr Reymond knew that Patient A lacked capacity to manage her own financial affairs, the GMC had first to prove that she lacked the relevant capacity. As it has not done so, it cannot prove that Dr Reymond knew that she lacked capacity in relation to finance. The Tribunal found paragraph 5c of the Allegation not proved.

Paragraph 5d

73. Dr Reymond gave evidence that Patient A asked him to assist by writing out cheques for her to sign to pay tax bills, medical fees and other expenses because she was 'struggling with her handwriting'. His evidence was that he always prepared these cheques in the presence of Patient A and under her direct instructions, believing her to have capacity to make decisions about finance. In answer to questions from the Judge at Southwark Crown Court Ms C said that there was at least one occasion when she believed that Dr Reymond took a signed blank cheque to his office for completion with the relevant payee, but admitted that she did not have a clear recollection of any specific date, or even year, when this occurred and indicated that she could not remember how often this happened. Ms C was not called to give evidence by the GMC and was not cross-examined in these proceedings. Taking account of all the evidence including the fact that the cheques were honoured by the bank, the Tribunal accepted Dr Reymond's evidence. Social services and other professionals deemed Patient A to have relevant capacity.

74. The Tribunal accepted Dr Reymond's evidence that he acted out of a sense of responsibility for Patient A as a good friend and doctor. Patient A asked Dr Reymond to help with financial issues and his evidence was that he did so in good faith. Dr Reymond told the Tribunal that he did not want to refuse to continue to act as Patient A's GP, nor to stop visiting her as a friend because he was her GP. Dr Reymond now accepts that there was a conflict of interest, because he was managing her finances at the same time as being Patient A's GP.

75. There was no need for any order from the Court of Protection or other formal authorisation for Dr Reymond to write out cheques for Patient A to sign. It was enough for Patient A to ask him to do this. To prove that Dr Reymond knew he was not lawfully authorised or permitted to manage Patient A's financial affairs, the GMC would first have to show that he was not so permitted or authorised. It has not established this. The Tribunal has found paragraph 5d of the Allegation not proved.

Paragraph 5h

76. Dr Reymond has acknowledged that there were deficits in his record keeping, both clinical and financial, at relevant times. However, the Tribunal accepts that he provided medical services to Patient A, mostly at home but also in hospital. The GMC did not adduce evidence to demonstrate that Dr Reymond charged more than other private doctors in the area or that his hourly rate was excessive. A brochure setting out charges for medical services dated 2010 was provided to the Tribunal.

77. Dr Reymond said that he visited Patient A in hospital and at home, both as a private GP and as a friend. The Crown Court heard evidence from Patient A's live-in carer Ms C that Dr Reymond attended Patient A's address twice a week or more during the relevant months. His presence was also noted by social services, Patient A's accountant and others. The Tribunal accepted his evidence that he charged for medical examinations or treatment, such as checking her hip, legs, blood pressure and other vital signs. Dr Reymond's written statement refers to a 'one-off' invoice dated 6 June 2011 provided to Patient A's accountant for £3600 for 36 visits in February, March, April, and May 2011. His evidence was that he had reduced his usual £250 fee to £100 to cover Patient A 's inpatient stay and a few weeks post-discharge. After that he charged his standard fee of £250 a visit or £500 a week for two visits, usually made on Tuesdays and Fridays.

78. The Tribunal accepted calculations provided by Mr Caplan on behalf of Dr Reymond. Taking a four-year period from late March 2011 to the end of 2015 Dr Reymond advanced £280 a month for food and other items, or at least £13,440 for 48 months. He charged £250 for each consultation at Patient A's home twice a week, which would amount to £26,000 a year or £104,000 for four years. The total amounts to about £117,000. The Tribunal accepted Mr Caplan's submission that these figures are comparable to those in the receipt book kept by Ms C and in cheques to Dr Reymond, as shown in Schedule 1. The receipt books show expenses paid of £14,376 and the cheques show fees/reimbursements not in the receipt

books of £105,370. The total of both figures is £ 119,746. This figure is based on receipt books and cheques from July 2011 until August 2015, with entries for expenses in Autumn 2015 of £980. These figures provided by Mr Caplan were not challenged by Mr Atherton. The Tribunal accepted their accuracy, in light of financial documents.

79. To prove that Dr Reymond knew he was not entitled to receive payments, the GMC would first have to show that he was not so entitled. It has not done so. The Tribunal found paragraph 5h of the Allegation not proved.

Paragraph 5i

80. The Tribunal accepted that Patient A was confused in hospital after surgery. Whether this confusion persisted after discharge, or for how long, was in dispute. Professor L cast doubt on the validity of assessments of capacity undertaken in Hospital in relation to Patient A's mental state post-discharge; he had access to evidence relating to Patient A's improvement at home. The Tribunal preferred his evidence to that of Dr N or Dr I as it was supported by clinical records and other information for 2012-2015. As there was no follow-up, the hospital doctors were unaware of Patient A's subsequent improvement at home.

81. As it was supported by Professor L and other witnesses, the Tribunal accepted the evidence of Dr Reymond that once Patient A had settled back in her home environment, her cognitive abilities improved significantly. The Tribunal also accepted his evidence that he discussed his fees for hospital visits with Patient A without delay.

82. In his witness statement Dr Reymond said that Patient A 'would often bring up in conversation the need to make sure that I was charging her for my time and asking me to let her settle up by way of a cheque'. This accorded with other evidence that Patient A made an effort to ensure payment to relevant companies and individuals, including clinicians and hospitals.

83. The GMC has not shown that it was more likely than not that Patient A had insufficient knowledge or understanding of her liability to make payments. To prove that Dr Reymond knew Patient A had insufficient knowledge or understanding to make the payments, the GMC would first have to show that this was indeed the case. It has not demonstrated this on the balance of probabilities. The Tribunal found paragraph 5i of the Allegation not proved.

Paragraph 6a

84. The Tribunal took account of Dr Reymond's good character and the fact that his consistent account of events was supported by other plausible evidence. It found as fact that Dr Reymond believed Patient A to have capacity to make decisions about bills, cheques and other financial issues at relevant times. The GMC has not discharged the burden on it to show that his words to Ms B were dishonest; he believed what he said and had good reason so to do.

Paragraphs 6b and 6c

85. The Tribunal has applied the test set out in *Ivey* and accepted Dr Reymond's evidence that he sought to assist Patient A when she asked him to help with financial issues. Dr Reymond believed, with good reason, that Patient A had capacity to make decisions about payments. The Tribunal found paragraph 6b and 6c not proved.

86. In summary, those particulars denied by Dr Reymond have been found not proved.

The Tribunal's overall determination on Facts

87. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

1. Between 2001 and September 2016 you were Patient A's private General Practitioner ('GP'). **Admitted and found proved**

2. From around February 2011 to January 2016 ('the Period'), you failed to:

    a. conduct or arrange a formal assessment and/or re-assessment of Patient A's mental capacity; **Admitted and found proved**

    b. make any reference to capacity in Patient A's GP clinical records; **Admitted and found proved**

    c. refer Patient A to a Dementia Assessment Service for assessment and management. **Admitted and found proved**

3. On or around 24 November 2011 you told Ms B that 'Patient A had made a huge recovery and was now able to make decisions about her finances' or words to that effect. **Admitted and found proved**

4. During the Period, you:

    a. wrote cheques for Patient A's signature which were payable to:

        i. yourself; **Admitted and found proved**

        ii. others; **Admitted and found proved**

b. received one or more payments from Patient A, as set out in Schedule 1 ('the Payments'). **Admitted and found proved**

5. You knew that during the Period:

a. there had been no formal re-assessment of Patient A's capacity; **Admitted and found proved**

b. Patient A was vulnerable; **Admitted and found proved**

c. Patient A's capacity to manage her financial affairs was impaired or was questionable; **Found not proved**

d. you were not lawfully authorised and/or permitted to manage patient A's financial affairs; **Found not proved**

e. there was a conflict of interest in respect of you managing Patient A's financial affairs whilst you were Patient A's GP; **Admitted and found proved**

f. the Payments were excessive for the consultations recorded in your GP records for Patient A; **Admitted and found proved**

g. there were no invoices and/or receipts to support and/or justify the Payments; **Admitted and found proved**

h. you were not entitled to receive the Payments; **Found not proved**

i. Patient A had insufficient knowledge and/or understanding of her liability to make the Payments. **Found not proved**

6. Your conduct at paragraph(s):

a. 3 was dishonest by reason of paragraph 5.a and 5.c; **Found not proved**

b. 4.a. was dishonest by reason of paragraphs 5.a to 5.e; **Found not proved**

4.b. was dishonest by reason of paragraph 5. **Found not proved**

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

Determination on Impairment - 12/08/2021

1. The Tribunal now has to decide in accordance with Rule 17(2)(l) of the Rules whether or not, on the basis of the facts which it has found proved, Dr Reymond's fitness to practise is impaired by reason of misconduct.

The Evidence

2. The Tribunal has taken account of all evidence, documentary and oral, provided at the facts stage of the hearing.

3. The Tribunal also received the following additional evidence on behalf of Dr Reymond which included but was not limited to:

- Personal development plan, dated 6 July 2021;

- Reading list;

  - GMC Guidance - Good Medical Practice (2013);
  - Duties of a doctor;
  - Professionalism in action (paragraphs 1-6);
  - Knowledge skills and performance (paragraphs 7-21);
  - Safety and quality (paragraphs 22-30);
  - Communication partnership and teamwork (paragraphs 31-52);
  - Maintaining trust (paragraphs 53-80);
  - GMC Guidance - Financial and commercial arrangements and conflicts of interest (2013);
  - Pulse Today Article: Dilemma: Vested Interests.

- Evidence of CPD;

  - The Mental Health Act and How to Put it into Practice, dated 8 November 2016;
  - Good record-keeping, dated 22 June 2021;
  - Advanced safeguarding children and vulnerable adults (Level 3), dated 22 June 2021;
  - Mental Capacity Act, dated 22 June 2021;
  - Safeguarding adults in primary care, dated 22 June 2021;
  - Deprivation of liberty safeguards CQC briefing, dated 22 June 2021;
  - Safeguarding vulnerable adults, dated 22 June 2021;
  - Guidance update latest NICE guidelines on dementia, dated 22 June 2021;
  - Assessing patients' capacity, dated 22 June 2021;

- Decision making and consent, dated 22 June 2021;
- Level 2 safeguarding adults, dated 22 June 2021;
- Decisions about patient care, dated 22 June 2021;
- Assessment of Older People, dated 4 December 2019;
- Espresso CPD Dementia Guidance Key Points, dated 23 June 2021;
- Polypharmacy in a Patient with Dementia - Nursing Home Case Study, dated 3 March 2021;
- Guidance update - latest NICE guidelines on multimorbidity, dated 16 January 2019;
- Comorbidities in older people, dated 6 September 2017;
- Guidance update - latest NICE guidelines on mental health, dated 11 June 2020;
- Delirium - red flag symptoms, dated 31 March 2020;
- Delirium - clinical review 26/02/2019.

- Testimonial evidence.

The Tribunal were also referred to the following GMC Guidance:

- Consent: patients and doctors making decisions together (2 June 2008);
- Financial and commercial arrangements and conflicts of interest (22 April 2013);
- Good Medical Practice 2006 ('GMP 2006');
- Good Medical Practice 2013 ('GMP 2013').

Submissions on behalf of the GMC

4. Mr Atherton submitted that the Tribunal should find that Dr Reymond's current fitness to practise is impaired by reason of misconduct, as admitted in relation to paragraphs 2, 4, 5a, 5b, 5e, 5f and 5g of the Allegation. He invited the Tribunal to consider 2, 5a and 5b together, taking account of expert evidence given by Dr K. Although the Tribunal's findings of fact are not in alignment with Dr K's opinion, Mr Atherton invited the Tribunal to consider Dr K's conclusions as to the seriousness of Dr Reymond's departures from Good Medical Practice (GMP).

5. In relation to paragraph 2, Dr K was critical of Dr Reymond's failure to conduct or arrange a formal assessment of Patient A's capacity to make decisions about financial issues after discharge from hospital in 2011, as well as subsequently. If his admission to paragraph 2 was based on acceptance of omissions as far back as 2011, it would appear to be inconsistent with the Tribunal's factual finding that Patient A did not lack relevant capacity following discharge home in 2011, but not if the admission related to 2015. In October 2015 a social worker Mr H found that Patient A did not have the requisite capacity to manage her finances and was unlikely to regain the ability to do so.

6. Mr Atherton said that Patient A had a 'rapid assessment' by a district nurse in January 2014, but the only people who carried out a formal assessment of capacity were Dr I and Dr

N in early 2011. He submitted that all subsequent assessments were a matter of 'impression', as opposed to formal assessments in accordance with the Code to the Mental Capacity Act 2005; anyone who saw Patient A as regularly as Dr Reymond should have realised that Patient A needed to be formally assessed in 2014 or 2015, if not before. But Dr Reymond had provided no formal reference to mental capacity in GP or other records.

7. In relation to 5a and 5b, Dr Reymond admitted that he knew that there had been no formal assessment of capacity and he knew that Patient A was vulnerable. Mr Atherton submitted that Dr Reymond had breached paragraphs 3a, 3i, 12 and 13 of GMP 2006 as he should have arranged a timely assessment or reassessment of capacity to make relevant decisions. His failure to do so, in light of Patient A's vulnerability and advice provided in 2014, represents a serious departure from GMP.

8. In relation to paragraph 3i of GMP 2006, Mr Atherton submitted that Dr Reymond should have recognised that it was appropriate for him to have taken specialist advice, particularly as there had been a diagnosis of dementia in 2011. By not doing so, Dr Reymond had breached paragraphs 12 and 13 of GMP 2006. Doctors must keep their knowledge and skills up to date, and be familiar with relevant guidelines. Although Dr Reymond has taken steps to redress these issues since 2015 his lack of knowledge of the Mental Capacity Act 2005 represented a significant deficit. Mr Atherton submitted that the admitted failures were serious and persisted for at least twelve months.

9. In relation to paragraphs 4, 5e, f and g of the Allegation, Mr Atherton alluded to the absence of GP records of home visits to Patient A. In this context several cheques listed in Schedule 1 cannot be justified by reference to documented visits or invoices. In the absence of any records, it could reasonably be inferred that nothing took place; but despite this Dr Reymond was paid. In that there were no clinical records of GP visits, those payments can be described as excessive.

10. In relation to 5g, there were no invoices or receipts to support or justify the payments. Dr K's conclusions as to conflict of interest are relevant to this admitted failure.

11. Mr Atherton referred the Tribunal to paragraph 3f of GMP 2006 when considering record keeping. He submitted that Dr Reynold's inability to justify the substantial payments by reference to medical or other records for a vulnerable patient, constitutes serious misconduct; it raises serious questions, but no answers have been provided. Mr Atherton submitted that, in this context, Dr Reymond's failure to keep records is likely to bring the medical profession into disrepute.

12. Mr Atherton alluded to relevant principles in relation to misconduct and impairment. Although Dr Reynold may have rectified deficits in his knowledge, Mr Atherton submitted that a great deal of damage has been done as a result of his misconduct, such that a finding of impairment is required to uphold proper professional standards and public confidence.

13. Mr Atherton reminded the Tribunal of the oral evidence of retired police officer, Mr C, who was involved in the fraud investigation in 2015. Despite HHJ Bartle QC finding no case to answer at Southwark Crown Court, Mr C retained his impression of a *"massive lack of transparency"* and thought that payments to Dr Reymond were *"unjustifiable"* as they *"couldn't be linked to professional fees or purpose"* by way of any documents. Mr Atherton asked the Tribunal to take account of his view that there had been fraud and an abuse of trust, despite the Judge-directed acquittal. Mr Atherton submitted that Dr Reynold's fitness to practise is impaired by reason of serious misconduct.

Submissions on behalf of Dr Reymond

14. Mr Caplan QC said that Dr Reymond accepts that those facts admitted and found proved amount to misconduct. He invited the Tribunal to find that current fitness to practise is not impaired, taking account of Dr Reymond's otherwise good record, the time that has passed since the events in question and all other circumstances. The Allegation relates to the months from February 2011 (ten years ago) to January 2016 (over five years ago). Dr Reymond was acquitted of any criminal offence three years ago in 2018.

15. Dr Reymond had accepted failures in three areas from the start. First, he had a lacuna in his medical knowledge of how to assess elderly patients generally and, in particular, with regard to mental capacity. Mr Caplan referred the Tribunal to the relevant sections of Dr Reymond's witness statement.

16. The second admitted failure related to Dr Reymond's record keeping, in relation to GP visits and financial issues. Mr Caplan submitted that, whilst these ought not to have happened, those gaps in the records arose in the context of unusual repetition; the professional service Dr Reymond provided to Patient A was two visits each week on an ongoing basis for several years. However, Dr Reymond recognises that he should have kept all of the records up to date; his explanation is not intended to justify his behaviour.

17. The third admitted failure was in relation to conflict of interest. Mr Caplan said that Dr Reymond recognises that his antennae should have been much sharper after Patient A was discharged from hospital. He was trying to do his best, by acting as her doctor, as well as her friend, assisting with financial affairs when required. At all times, he sought to do what was best for Patient A, in accordance with her requests; he did not want to let her down.

18. However Dr Reymond confirms in his witness statement that he is deeply remorseful about crossing the professional boundary which should be maintained between doctor and patient. In trying to assist Patient A as a practitioner and as a friend, he went too far. Mr Caplan drew attention to Dr Reymond's good intentions, as well as his insight into transgressions.

19. Mr Caplan referred to GMC guidance 'Financial/ commercial arrangements and conflicts of interest' dated 22 April 2013. This says that conflicts of interest are not always identifiable or avoidable. Appropriate steps to mitigate risk depend on the circumstances. Dr

Reymond accepts that a doctor should try to err on the side of caution; also that he did not avoid a conflict of interest with Patient A.

20. Mr Caplan referred the Tribunal to Dr Reymond's CPD certificates, personal development plan (PDP) and reading list. He submitted that these demonstrate that Dr Reymond has addressed the areas which are the subject of the admissions.

21. Mr Caplan submitted that Dr Reymond has been fully registered as a general practitioner since 1994 and there have been no issues with his registration other than in relation to this Allegation. His career is otherwise unblemished.

22. There is no presumption of impairment in this case. It is for the Tribunal to determine, in all the circumstances, whether or not, by reason of the admitted facts, Dr Reymond's fitness to practise is currently impaired. Mr Caplan submitted that this is a unique case: Dr Reymond had treated Patient A since 2001 and knew her well; Patient A desperately wanted to leave hospital and return to her flat. Dr Reymond and others in the French community tried to do all they could to fulfil her wishes and ensure that all her needs were met in the comfort of her own home; such unusual circumstances are very unlikely to occur again.

23. Dr Reymond had very much learned from the experience of being on trial at a Crown Court in front of a judge and jury. He has now been obliged, for the second time, to contest an allegation of dishonesty; the process has caused him XXX. Dr Reymond has provided detailed testimonial evidence as examples of his professionalism.

24. Mr Caplan submitted that Dr Reymond has considerable insight, as he has recognised his flaws, where he went wrong and taken steps to remediate those flaws and the lacuna in his knowledge, as his CPD and reading list demonstrate. His record keeping reflects what he has learned; Dr Reynold has read about, and considered, where conflicts of interest could arise, in other situations. He accepts that it is not sufficient for him to say he wanted to act for the best; if a conflict were to arise in future, he would declare it, seek advice as necessary, and then remove himself from any situation involving a conflict of interest.

25. Mr Caplan said that, in relation to his admissions Dr Reymond admits misconduct. However, he submitted that Dr Reynold presents no risk to the public and a finding of impairment is not otherwise required in the public interest. He invited the Tribunal to conclude that fitness to practise is not impaired by reason of misconduct over five years ago, in the context of a long successful career, usual professionalism, insight and remediation. Mr Caplan submitted that Dr Reymond is now fit to practise; there is no current impairment.

The Tribunal's Determination on Impairment

Legal advice and the Tribunal's approach

26. The Tribunal reminded itself that at this stage of proceedings, there is no burden or standard of proof and the decision on misconduct and impairment is a matter for the Tribunal's judgement alone. It has analysed the evidence in the context of submissions by counsel and principles in relevant authorities.

27. The Tribunal must determine whether or not Dr Reymond's fitness to practise is impaired today, taking into account Dr Reymond's conduct at the time of the events and any relevant factors since then such as whether the matters are remediable, have been remedied and any likelihood of repetition.

28. The Legally Qualified Chair ('LQC') gave legal advice in the hearing:

29. Impaired is an ordinary word in common usage, not defined in the Medical Act. There is no burden or standard of proof, it is a question of judgement.

30. Impairment may be based on historical matters or a continuing state of affairs, but it is to be decided at the time of the hearing. To do this the Tribunal must look forward taking account of any reparation, changes in practice, conduct or attitude since the matters found proved actually occurred. An effort to accept and correct remediable errors should be taken into account.

31. *Meadow v GMC 2006 EWCA Civ 641* provides that a Tribunal should take account of the need to protect individual patients as well as to maintain confidence in the medical profession.

32. *Cohen v GMC 2008 EWHC 581* confirms that a Tribunal should consider whether misconduct is easily remediable, has been remedied and the extent to which such behaviour is unlikely to be repeated.

33. *CHRE v NMC & Grant 2011 EWHC 927* cites the Fifth Shipman report. In determining impairment the Tribunal must consider whether or not its findings of fact in respect of Dr Reymond's admissions indicate that his fitness to practise 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 a patient or patients at unwarranted risk of harm; and/or*
> *b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
> *c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession …*

34. *Yeong v GMC 2009 EWHC 1923* provides that the need to maintain public confidence in the medical profession and declaring/upholding standards of behaviour may mean that a doctor's fitness to practise is impaired by reason of certain acts of misconduct of themselves. This is because the public simply would not have confidence in him, or in the profession's standards, if the Tribunal regarded that sort of conduct as leaving fitness unimpaired. A

finding may be necessary to reaffirm to the public and doctors the standard of conduct expected of them.

35. *Chaudhury 2017 EWHC 2561* reminds Tribunals of the importance of the overarching objective, the tripartite public interest and the need for Tribunals to conduct a proper balancing exercise of all three elements of the public interest test, rather than to focus on just one aspect of the test.

36. Good Medical Practice and other relevant guidance should be taken into account. The Tribunal will decide this case on its merits.

37. After this, both counsel were notified that the Tribunal would also take account of principles in *Remedy UK v GMC 2010 EWHC 1245 GMC v Armstrong 2021 EWHC 1658* in relation to misconduct and impairment, which alludes to the Tribunal's duty to uphold professional standards and the wider public interest.

38. Mr Atherton provided further submissions by email on 3 August 2021:

In *Meadow v GMC [2006] EWCA Civ 1390* the Court of Appeal stated:

> "Misconduct must be linked to the practice of medicine or conduct that otherwise brings the profession into disrepute and it must be serious-the sort of conduct which would be regarded as deplorable by fellow practitioners"

He also cited *CHRE v Grant* in the context of deplorable conduct:

> "The Committee should therefore have asked themselves not only whether the Registrant continued to present a risk to members of the public, but whether the need to uphold proper professional standards and public confidence in the Registrant and in the profession would be undermined if a finding of impairment of fitness to practise were not made in the circumstances of this case...."

39. Mr Caplan provided further submissions by email on 9 August 2021:

1. [Impairment] is an ordinary word that has no statutory definition. In each case it is a matter for the judgment of the Tribunal.

2. Stage 2 raises two issues. Firstly, do the facts as proved amount to misconduct? Secondly, as a result of the facts proved, is the doctor's fitness to practice currently impaired by reason of the misconduct? A finding of misconduct does not answer the second question which must be considered independently: *Cohen v GMC (2008) EWHC 581 (Admin) para 64.*

3. The emphasis in the second question is on "current" impairment.

4. The factors that the Tribunal should consider when considering current impairment are varied.

A: The factors will include **a personal assessment.** For example:

a) Whether the practitioner now presents a risk to members of the public? What is the risk of repetition?
b) does the practitioner have insight and what steps have been taken to remediate?
c) are there otherwise positive testimonials?
d) is this an isolated lapse in an otherwise unblemished career?

B: The factors will also include an assessment of **how serious the misconduct was** in all the circumstances. Dishonesty and sexual assault are clearly examples at the serious end of the scale. Cases where the practitioner mistakenly believed that he was acting in the patient's best interest are at the other end of the scale. *"Not every case of misconduct will result in a finding of impairment. An example might be an isolated error of judgment which is unlikely to recur where the misconduct is not so serious as to render a finding of impairment plainly necessary" Inner House of the Court of Session (2017) [PSA v NMC 2017 CSIH 29 at paragraph 27; also] paragraph 42 of the judgment in GMC v Armstrong (2021) EWHC 1658 (Admin).* Clearly the punishment must fit the crime.

C: The factors will also have regard to the need for the regulatory regime to maintain **the trust and confidence of the public** in the profession. Courts of law have a similar objective when passing sentence. In short, would members of the public fully informed of the circumstances regard a finding of no impairment as undermining the trust and confidence element? This does not mean that a Tribunal should take a course which it otherwise finds harsh or unnecessary. It means that its decision-making process should be rational and open to public scrutiny. If, for example, a Tribunal regards a case as exceptional then it is entitled to say so and to explain why. It is undue and inexplicable leniency that risks undermining public confidence.

40. In this context, section 40A(3) of the Medical Act 1983 (which provides for an appeal by the GMC where it is considered that the Tribunal's decision is not sufficient for the protection of the public) is essentially concerned with cases where it is submitted by the GMC that the Tribunal acted irrationally or perversely and that no reasonable Tribunal could have reached that decision in all the circumstances having regard to the relevant factors.

Facts Relevant to Impairment

41. In determining issues in dispute, as well finding proved those matters admitted by Dr Reymond, the Tribunal has been aware that the word 'during' used in the stem of paragraphs 4 and 5 of the Allegation has two dictionary definitions. First, throughout the duration. Second, at some point or points in the course of the relevant time.

42. The Tribunal has sought to interpret the word 'during' used in the Allegation in its natural sense in relation to each particular. The word 'during' cannot be interpreted to mean every moment of every day throughout the duration. However, it would not suffice for Patient A to have very sporadic capacity to make financial decisions or to retain decision-making capacity for only a few months.

43. Patient A was sometimes asleep when Dr Reymond visited in 2015 and there is evidence that her mental state may have fluctuated in later years, as HHJ Bartle recognised. In determining that Patient A had relevant capacity in those areas requiring decisions to be taken, during the years identified, the Tribunal has adopted a broad approach.

44. Determining whether or not a person has capacity to make specific decisions has to take account of principles in the Mental Capacity Act 2005, which recognises the concept of fluctuating capacity. Section 1(2) states that there is a presumption of capacity. A person is not to be treated as unable to make a decision unless all practicable steps to help have been taken without success: section 1(3). An 'unwise' decision cannot be said to be evidence of a lack of capacity to make decisions about financial issues: section 1(4).

45. Reasonable adjustments, such as providing extra time or home visits, can be appropriate to overcome physical or psychological barriers to accessing health services. Obstacles could include limited manual dexterity or memory issues. A doctor need not be familiar with the minutiae of the Code to the 2005 Act to adapt their usual practices to assist a person to absorb, retain, weigh and use information, to make and communicate a decision.

46. At the Facts stage, the Tribunal determined that the GMC had not discharged the burden on it to prove to the civil standard that, during relevant months, Dr Reymond knew that Patient A's capacity to manage her financial affairs was impaired or questionable; or that he was not lawfully authorised or permitted to manage Patient A's financial affairs while he was her GP; or that he was not entitled to receive payments at Schedule 1; or that Patient A had insufficient knowledge or understanding of her liability to make those payments.

47. To prove those disputed particulars of the Allegation 5c 5d 5h 5i, the GMC would first have had to prove the assertions on which they were based, but it did not do so. If the Tribunal was incorrect to find any of those premises not proved to the civil standard, the GMC would still have had to prove that Dr Reymond *knew* that the position was as alleged at paragraph 5. The Tribunal found as fact that he did not *know* any of those particulars alleged at 5c 5d 5h or 5i. Furthermore, the GMC did not discharge the burden on it to prove that Dr Reymond was dishonest.

48. Although unnecessary to make positive factual findings in relation to Patient A's mental state, the Tribunal also found that Patient A recovered capacity to make decisions about finance once discharged home from hospital in 2011. Professor L supported Dr Reymond's opinion that Patient A had experienced a temporary post-operative delirium. The Tribunal accepted the veracity of Dr Reymond's account of events, because it was consistent with documentary and other cogent evidence of Patient A's ability to make financial decisions.

49. The Tribunal has found that Patient A had relevant capacity to authorise payment. In other words, whenever Dr Reymond wrote out a cheque payable to himself for her to sign, Patient A understood that he had provided medical services for which he was entitled to be paid. The Tribunal considered that Patient A was able to understand relevant information, to retain, weigh and use it in deciding to authorise payments between 12 July 2011 and 25 August 2015.

50. Little or no weight was given to the evidence of Dr K or Mr C, as neither had been provided with evidence of Patient A's post-discharge recovery given at Southwark Crown Court, so could not take account of it. Dr K and Mr H both considered the assessments of Dr I and Dr N to apply in subsequent years 2012-2015, but the Tribunal has not made any such inference, for reasons given at the Facts stage of these proceedings.

51. The fact that Patient A was confused in hospital post-operatively when anaemic, hyponatraemic and affected by morphine, Quetiapine, pain and distress at being in an unfamiliar environment, does not indicate that she lacked capacity to make financial decisions once no longer affected by those adverse factors. Although Mr H found that Patient A lacked capacity to make financial decisions on the date of his formal assessment in October 2015, a lack of capacity to understand financial information from 2011 cannot be inferred, in view of significant evidence to the contrary from a range of professionals involved. It was on this basis that HHJ Bartle found no case to answer in relation to the fraud charge.

52. GMC submissions on impairment focused on public trust and confidence, as well as maintaining standards, as opposed to risk. Those particulars found not proved are potentially relevant to public perception, in view of information about Dr Reymond's trial being in the public domain.

Admissions

53. The months covered in paragraphs 2, 3, 4, 5 and 6 of the Allegation are February 2011 to January 2016 and start four months before the first cheque in July 2011 and extend five months after the last date (in the left column) of Schedule 1. Although no months were specified in relation to admissions made, the evidence indicates that Patient A was most vulnerable immediately after surgery in February 2011 and from September 2015 when there appears to have been a deterioration in mental faculties, observed by Dr Reymond and others.

54. Dr Reymond gave consistent, plausible evidence about his efforts to assist Patient A, a good friend, to return home and retain as much independence as was feasible in the circumstances, with the support of a live-in carer and others. He could have refused to continue as GP and/or to manage finances, but found it hard to do so when Patient A and friends at the French embassy urged him to help. He admitted failing to identify and respond to this conflict of interest.

55. Dates specified in Schedule 1 relate to paragraph 4 of the Allegation. Dr Reymond has admitted to writing cheques for signature between July 2011 and August 2015. The Tribunal has accepted his evidence that he wrote out cheques in Patient A's presence and in accordance with her specific, capacitous instructions.

56. In relation to admissions to paragraph 5a 5b 5e 5f 5g, the Tribunal has used the same natural interpretation of the word 'during' as indicated above. At various points or times between 2011 and 2015, when Dr Reymond visited Patient A as a friend and doctor, he knew that Patient A was vulnerable and was also aware of a (potential or actual) conflict of interest between his roles as treating clinician and friend assisting with financial affairs. He accepts that he knew there was no formal assessment of capacity after discharge.

57. Despite providing three invoices, the Tribunal accepted Dr Reymond's admission that several payments to him were not reflected by invoices, receipts or GP records for Patient A. There were no documents to support or justify most of his fees and some other payments.

58. Dr Reymond's evidence at the Facts stage is also relevant to the question of Impairment. He has admitted flaws in his approach to Patient A, due to a lacuna in his knowledge of the Mental Capacity Act 2005 and Code. In order to determine the extent to which his evidence indicates remorse, insight and remediation, the Tribunal took account of his evidence, which it considered to be accurate and truthful. He affirmed and was questioned in detail. His answers in relation to all particulars (both admitted and denied) were consistent and not undermined by documents; he gave a plausible account of events, as well as his intentions at the time.

59. Dr Reymond accepted, in his oral evidence, that there was a big gap in his knowledge of mental capacity in 2011-2016. He had written a referral letter dated 7 June 2010 to Dr Pellerin (Cardiologist) to say that; "Patient A has also started to have slight episodes of mental confusion, but at other times remains very alert". However, Dr Reymond told the Tribunal that Patient A was totally independent before 2011 and spoke numerous languages. Although there is no use of the word 'capacity' it is clear that he was observing her mental state as well as physical health.

60. At her insistence, Dr Reymond charged for professional visits, but 'obviously' not for social visits. Patient A was a 'very good friend' as well as a patient. When in hospital in 2011 Patient A kept saying 'take me home'. His professional opinion was that she had acute delirium syndrome, an assessment borne out by her recovery to her usual state once home.

When he heard reference made to dementia, Dr Reymond did not believe any such diagnosis to be correct.

61. Dr Reymond declined to be named in any LPA after the MDU advised that it would lead to a conflict of interest. His flawed judgement in not further distancing himself was in the context that Patient A said she did not want to deal with anyone else.

62. Dr Reymond fully accepts that he had a responsibility to keep records, even for frequent repetitive check-ups. As Patient A had trouble with handwriting, he filled in cheques for her signature, always under her direction. When first discharged home, Dr Reymond did not regard Patient A's capacity to make decisions as being in question. However, in 2015 she became increasingly forgetful and started gradually to lose capacity, before a very quick deterioration later that year.

63. Dr Reymond gave evidence that Patient A understood enough to authorise cheques at relevant times. As soon as Dr Reymond thought Patient A should no longer sign, he stopped writing cheques out.

64. At the time Dr Reymond thought Patient A was in the best situation, but he now realises that he should have seen it differently. It seemed to be a temporary situation and she appeared to be 'happy at home'. Dr Reymond thought he was doing right by Patient A but, he told GMC counsel in cross examination: 'I understand your suspicion'. His grandmother had had an experience with delirium in hospital and this appeared similar to him. Patient A was like a different person after one week at home in 2011, with a good ability to make decisions about financial issues; this continued until after mid-2015.

The Tribunal's Determination on Impairment

Misconduct

65. Misconduct may be described as a wrongful or inadequate mode of performance of professional duty. The Tribunal accepted Mr Atherton's submission that misconduct must be linked to the practice of medicine, or be conduct that otherwise brings the profession into disrepute: *Meadow v GMC 2006 EWCA Civ 1390*.

66. This principle was confirmed in *Remedy UK v GMC 2010 EWHC 1245* in which the High Court said that misconduct is of two principal kinds:

> First, misconduct going to fitness to practise in the exercise of professional medical practice.
>
> Second, morally culpable or otherwise disgraceful conduct, outside or within professional practice. Conduct falls into the second category if it is dishonourable or attracts some kind of opprobrium – that fact may be sufficient to bring the profession of medicine into disrepute and it does not matter whether or not directly related to the exercise of professional skills.

Action taken in good faith and for legitimate reasons, however inefficient or ill judged, is not capable of constituting misconduct within the meaning of section 35 merely because it *might d*amage the reputation of the profession.

67. The Tribunal took account of paragraphs 3a, g and i, 12 and 13 of GMP 2006:

"3. In providing care you must:

a. recognise and work within the limits of your competence

…

g. make records at the same time as the events you are recording or as soon as possible afterwards

…

i. consult and take advice from colleagues, when appropriate"

"12. You must keep your knowledge and skills up to date throughout your working life. You should be familiar with relevant guidelines and developments that affect your work. You should regularly take part in educational activities that maintain and further develop your competence and performance.

13. You must keep up to date with, and adhere to, the laws and codes of practice relevant to your work."

68. The Tribunal considered paragraphs 11, 16d, 19 and 21 of GMP 2013, too:

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

"16. In providing clinical care you must:

…

d. consult colleagues where appropriate"

"19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards."

"21. Clinical records should include:

a. relevant clinical findings

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c. the information given to patients

d. any drugs prescribed or other investigation or treatment

e. who is making the record and when."

69. The Tribunal also considered GMC Guidance 'Financial and commercial arrangements and conflicts of interest' dated April 2013, which says:

"11 Conflicts of interest are not always avoidable, and whether a particular conflict creates a serious concern will depend on the circumstances and what steps have been taken to mitigate the risks, for example, by following established procedures for declaring and managing a conflict.

12 You should:

a use your professional judgement to identify when conflicts of interest arise

b avoid conflicts of interest wherever possible c declare any conflict to anyone affected, formally and as early as possible, in line with the policies of your employer or the organisation contracting your services

d get advice about the implications of any potential conflict of interest

e make sure that the conflict does not affect your decisions about patient care."

70. Dr Reymond has accepted that his behaviour amounted to misconduct, as submitted by the GMC. However, the Tribunal must determine whether or not those facts admitted and found proved amount to misconduct, taking account of all evidence and submissions by counsel as to seriousness.

Medical Records

71. The Tribunal accepted that Dr Reymond found himself in a highly unusual situation. Patient A told Dr Reymond and those in the French community that she wanted to go home from hospital and avoid institutional care. Dr Reymond and others in the French community did all they could to enable her to retain autonomy and the independence she considered to be so important.

72. As Dr Reymond was a private GP in sole practice, he may well have retained and referred to medical records for Patient A without providing access to any other clinician. Despite this, the Tribunal considered that record keeping is important for all doctors to ensure good care and to comply with GMP, which stipulates that every registered medical practitioner must keep records.

73. The Tribunal took account of testimonials, including a letter dated 7 July 2021 from Mr Amish Patel, Director and Lead Pharmacist, Strickland Pharmacy, which said:

> "I have known Dr Reymond in a professional capacity since 2009. I first established contact with Dr Reymond when he was a general practitioner practising at The Health Partnership…
>
> The pharmacy has looked after many of Dr Reymond's patients over the years, and their feedback [about] him [is] always very positive; in particular they comment on his professionalism, clinical thoughtfulness, and sympathetic manner. To date we have never received a negative comment or review against Dr Reymond from any of his patients or the community, aside from [this] investigation.
>
> With regards to Dr Reymond's clinical prescribing, it is exceedingly rare that we come across any discrepancies, and if there are any queries, he is always at hand to explain his rationale on prescribing or rectify any mistakes he made. His clinical knowledge of medicines is one of the best that we have come across and he always demonstrates his eagerness to build on his knowledge and learn about new medications, or any changes that may occur from a treatment perspective. He frequently calls the pharmacy to discuss drug efficacy and pharmacology for his patients again demonstrating the conscientious way in which Dr Reymond conducts himself for the best outcomes for his patients and their welfare. He is always striving to go above and beyond when caring for his patients."

74. Testimonials and other documentary evidence indicate that Dr Reymond generally kept good records. He used an electronic system to scan in blood test results for Patient A, referral letters and reports from consultants. The Tribunal was provided with over 50 pages of medical records from 2001-2016. Dr Reymond noted clinical issues including conjunctivitis and a fall attended by paramedics in 2013, after which he visited and found her to be 'perfectly well'. These entries are all dated and timed. Detailed blood test results are recorded in 2014-2015; there are references to cardiac issues and oedema, as well as loss of hearing with audiology graphs.

75. Dr Reymond did not enter notes after routine home visits to Patient A, but he did record significant changes to physical or mental health. An undated entry in GP records, just after 26 March 2010 says: '… slight confusion in relation [to] her depression. She doesn't want any treatment, but I asked the cleaner to try to take her to specialist for elderly'. This reflects a willingness to liaise with others close to Patient A. Nevertheless, Dr Reymond recognises that accurate contemporaneous records should have been kept for each home visit to Patient A, no matter how routine or unremarkable his findings, to monitor her health, treatment and any responses to medication. Dr Reymond has admitted that he failed to make any explicit reference to 'capacity' in Patient A's clinical records for almost five years.

76. Failure to keep GP records for any patient, especially if vulnerable, would constitute an inadequate mode of performance of professional duty. However, the Tribunal did not accept Mr Atherton's submission that there were 'no GP records for home visits *or checks*' because numerous pages of his GP records for Patient A, with detailed clinical data for relevant years, were provided. The Tribunal considered Dr Reymond's failure explicitly to use the word 'capacity' in Patient A's clinical records to be a minor breach of paragraph 3(g) of GMP 2006 in 2011 and/or paragraph 21 of GMP 2013 in 2014-2015. However his persistent failure to make records of home visits to Patient A was more significant, in light of the fact that fees were charged.

77. The Tribunal has to consider Dr Reymond's failure to refer explicitly to 'capacity' in the context of the whole GP record and other relevant circumstances. He made a clear record of any significant changes in Patient A's presentation, using words such as 'alert,' 'capable,' 'understanding,' 'confusion' or 'depression' as appropriate, but did not make a note of routine findings. In these circumstances, the Tribunal does not consider his misconduct in relation to records to be serious: paragraph 2b of the Allegation.

Assessment of capacity - Mental Capacity Act 2005

78. The Tribunal had regard to GMC Guidance 'Consent: patients and doctors making decisions together' dated 2 June 2008, which said:

> *"71 You must assess a patient's capacity to make a particular decision at the time it needs to be made. You must not assume that because a patient lacks capacity to make a decision on a particular occasion, they lack capacity to make any decisions at all, or will not be able to make similar decisions in the future.*
>
> *72 You must take account of the advice on assessing capacity in the Codes of Practice that accompany the Mental Capacity Act 2005… If your assessment is that the patient's capacity is borderline, you must be able to show that it is more likely than not that they lack capacity.*
>
> *73 If your assessment leaves you in doubt about the patient's capacity to make a decision, you should seek advice from:*
>
> *a nursing staff or others involved in the patient's care, or those close to the patient, who may be aware of the patient's usual ability to make decisions and their particular communication needs*
>
> *b colleagues with relevant specialist experience, such as psychiatrists, neurologists, or speech and language therapists.*
>
> *74 If you are still unsure about the patient's capacity to make a decision, you must seek legal advice with a view to asking a court to determine capacity."*

And further:

> *"Section 1 of the Act sets out five statutory principles that apply to any action taken and decisions made under the Act. These are:*
>
> *(1) a person must be assumed to have capacity unless it is established that they lack capacity*
>
> *(2) a person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success"*

79. In his witness statement Dr Reymond said: "I regret that I did not arrange for a formal assessment which was due to my lack of experience with elderly patients and capacity issues in general. I agree with the social services assessment dated 28 September 2015 which concluded that by then [Patient A] had lost capacity."
The Tribunal considered that it would have been good practice to conduct or arrange a formal assessment of Patient A's mental capacity before September 2015. Dr Reymond failed to take account of guidance that an assessment should take place when there is a concern that an individual may lack mental capacity to make a proposed decision.

80. A psychiatric report concluding that Patient A had capacity to make decisions about residence, care and treatment could have protected her from a premature, or wrongful, deprivation of liberty. Soliciting an expert opinion would have been a more effective response to Dr Reymond's concern that Patient A was at risk of an early or unwarranted loss of autonomy purely based on a mental capacity assessment skewed by post-operative factors.

81. Dr Reymond has admitted failing to conduct or arrange a formal assessment or reassessment of Patient A's mental capacity between February 2011 and January 2016: Allegation paragraph 2a. It was in January 2016 that Dr Pellerin referred to dementia, by which time Dr Reymond would have seen Mr H's report. Once other professionals were involved with Patient A, Dr Reymond had less responsibility for ensuring any further assessment. Nevertheless, he has also admitted failing to refer Patient A to a Dementia Assessment Service: Allegation paragraph 2c.

82. Social worker Mr H concluded that Patient A was not able to understand or recall information about her finances on the day he assessed her in October 2015. Patient A did not know this assessor, and his report postdates 25 August 2015 when Dr Reymond last wrote out a cheque for signature. Mr H's opinion is not conclusive as to Patient A's mental capacity when supported by familiar people in August 2015. However, Dr Reymond had expressed concerns about Patient A's memory and understanding the previous year, so should have taken earlier action.

83. The Crown Court heard evidence about an email from Dr Reymond to Ms C on 10 February 2014:

'I think we are reaching a point where I don't know if [Patient A] is still capable of understanding what is going on and especially for the cheques. I need to have contact with her and I don't know if she remembers me anymore. I think we have to organise a power of attorney with the social services which I don't really like them to be involved as they might want to put her in a home. What do you think as I trust your judgment? See you. Dr Reymond'.
Ms C replies:
'Thank you I acknowledge your email regarding my clients state of mind and requesting my opinion on how to manage her finances. On my opinion as I have no idea on how this works, I suggest you seek professional advice. Regards'

84. Ms C told the Judge that Dr Reymond called when he got her reply, but they had no further discussions about power of attorney. Nor was this discussed with the accountant at the time.

85. A Social Worker ('SW') spoke to Dr Reymond on 15 April 2014 and noted:
"SW rang Dr Reymond - Private GP, The health partnership.
Dr Reymond states that he is [Patient A's] next of kin…
Dr Reymond stated that he has been the private GP for Patient A for past 20 years during which time they became friends and he has been assisting her with various matters.
SW advised that he has contacted [X] and they informed that they assist with management of finances in consultation with Dr. Reymond. He agreed.
SW enquired if anyone has a LPA. Dr Reymond stated that no one has it yet and asked SW for further advice. He informs that he has approached Patient A along with a solicitor to discuss about this in past but she was dismissive.
SW advised that they need to consult a solicitor to get further advise. Also a Mental capacity assessment needs to be completed to assess Patient A's capacity to manage her finances. SW also advised him to refer to the OPG website to get more information. Dr Reymond agreed for it. SW advised that it is very important that formal arrangements are put in place to assist Patient A with managing her finances. He agreed to deal with this."

86. Various professionals discussed the option of a Lasting Power of Attorney (LPA), including an accountant and solicitor whom Dr Reymond had asked to assist Patient A in 2014. As nobody progressed this with Patient A (who would need capacity to authorise an LPA) Dr Reymond was left to continue managing Patient A's finances, with her bank's full knowledge. Around this time she was described as having 'good days and bad days' implying some fluctuation.

Conclusions

87. It was not submitted that Dr Reymond poses a risk to patients, or that he caused harm to Patient A. Although impairment is to be decided at the time of the hearing, a finding of impaired fitness to practise may be based on past misconduct.

88. No culpability attaches to Dr Reymond's admission to paragraph 1 of the Allegation, that he was Patient A's GP. The Tribunal accepted that Dr Reymond spoke sincerely and honestly in November 2011 to Miss B, when he said that Patient A had made a 'huge recovery' and was now 'able to make decisions' about her finances; therefore paragraph 3 of the Allegation does not amount to misconduct.

89. Dr Reymond has admitted writing out cheques for Patient A to sign, payable to himself and others: paragraph 4 of the Allegation. Although his financial records were inadequate, he was entitled to be paid for medical services and reimbursed for expenses. In the context of her age, health issues and relative isolation, the Tribunal considered that paragraph 5e amounted to misconduct in light of 5b. In other words, Dr Reymond should not have allowed a conflict of interest to arise or persist with Patient A, who was vulnerable.

90. Writing out cheques for signature raises legitimate questions; many were answered in this hearing, but Dr Reymond has not sought to justify deficiencies in his (medical or) financial records. Invoices for medical fees should be provided to patients, but no evidence was adduced of an obligation to include them in clinical records. Dr Reymond has admitted that the payments were 'excessive for the consultations recorded in GP records' for Patient A; also that they were not justified by invoices or receipts: Allegation paragraphs 5f and 5g. But Dr Reymond did undertake GP visits twice a week, so was being paid for medical services provided.

91. The Tribunal has found that Dr Reymond's failure to use the word 'capacity' or consistently to record details of home visits in Patient A's GP clinical records to breach good practice. He has admitted misconduct in relation to his admissions as a whole. Even if Patient A could not attend appointments in his office, Dr Reymond could have used a notebook for later transfer to his electronic GP records.

92. Mr Caplan has provided strong evidence on behalf of Dr Reymond that his deficient record-keeping in relation to Patient A has been remedied as fully as is possible. The Tribunal must look forward, taking account of any reparation, changes in practice, conduct or attitude since the matters found proved actually occurred. An effort to accept and correct remediable errors should be taken into account, but it is not determinative, as the Tribunal must take account of the wider public interest.

93. Dr Reymond was attentive to Patient A, who remained well at home for at least four years after discharge from hospital in March 2011. The Tribunal did not consider that he had posed any risk to Patient A, whom he helped in many ways. His testimonials indicate that he is a conscientious, professional and empathic doctor.

94. However, the Tribunal had to take account of the overarching objective and the tripartite public interest, considering all three (overlapping) elements of the public interest test, as opposed to focusing solely on risk of harm. Public perception is influenced by the degree of risk posed; public trust is less likely to be undermined if a doctor poses no risk to patients.

95. The Tribunal considered relevant parts of the test in *Grant 2011*: whether or not facts admitted/found proved indicate that Dr Reymond's fitness to practise is impaired in the sense that he has brought the medical profession into disrepute, or breached any fundamental tenet/s of the medical profession, or that he is liable to do so in the future.

96. Any impact on public trust in the medical profession should be assessed in the context of information about Dr Reymond in the public domain. Crown Court trials are held in public, so HHJ Bartle's comments should be taken into account by the Tribunal in assessing the impact, if any, of Dr Reymond's misconduct on public trust and confidence. Despite any lingering suspicion from a retired police officer, HHJ Bartle judged that there was no cogent evidence of fraud.

97. In finding no case to answer HHJ Bartle said:

> "…In my judgment, on the basis of this powerful evidence [from prosecution witness] coupled with the fact that [Ms C] closed the case because she considered [Patient A] had capacity, any reasonable jury properly directly could only conclude that [Patient A] regained capacity to manage her financial affairs after her discharge from hospital until 23 August 2015 when she signed her last cheque to Dr Reymond and therefore, they could not find him guilty of count one.
> Fourth, if I am wrong that a reasonable jury properly directed could only conclude that [Patient A] regained capacity to manage her financial affairs, the cumulative effect of the chronology set out above is consistent only with Dr Reymond's belief that [Patient A] had fluctuating capacity in the issuing of cheques with which he assisted and there are no other co-existing circumstances which would weaken or destroy such an inference. Accordingly, on that basis a reasonable jury properly directed could only conclude that Dr Reymond believed that [Patient A] had fluctuating capacity in the issuing of cheques and therefore they would have to find him not guilty of count one.
> Fifth, Dr Reymond's reluctance to involve himself with the responsibilities pursuant to an LPA, POA or the Court of Protection application is inconsistent with an intention to gain access to [Patient A's] finances and no jury properly directed could draw an inference adverse to his case."

98. The Tribunal noted that there was no formal mental capacity assessment after Patient A's discharge from Hospital in March 2011 until October 2015. Several professionals made informal assessments of her capacity to understand financial information and authorise

cheque payments, including two social workers, a live-in carer and a bank manager who visited Patient A. Professor L confirmed that early-stage dementia does ***not*** preclude capacity to make financial decisions. However, Dr Reymond accepts that he should have arranged an assessment in the context of his concerns about Patient A.

99. Although he sought advice from the MDU and declined to be appointed to any formal role by the Court of Protection, Dr Reymond should have considered the wider scope and implications of a conflict of interest. He did not want to 'abandon' Patient A, but he could have transferred clinical care to another French doctor. He should have tried to explain to her that he should not be both friend and doctor.

100. GMC guidance recognises circumstances where conflicts of interest are difficult to identify, or to avoid. The Tribunal accepts that Dr Reymond was in an objectively difficult position, but he should have distanced himself earlier, taking broad account of advice on a similar issue from the MDU.

101. The need to maintain public confidence in the medical profession and to uphold standards of behaviour may mean that a doctor's fitness to practise is impaired by reason of certain acts of misconduct of themselves. Dr Reymond's misconduct persisted over time, so cannot be described as an isolated lapse.

102. The Tribunal did not consider Dr Reymond's actions to breach a fundamental tenet of the medical profession, such as doing no harm, or probity, considered in *Armstrong*. A reasonable, objective member of the public, fully informed as to facts would be unlikely to condemn his actions. Dr Reymond's admissions to parts of the Allegation and his acceptance that these amount to misconduct confirm that he has insight into his flaws. The Tribunal has taken account of his otherwise good record, the time that has passed since the events in question and all other circumstances.

103. In 2010 the High Court said that misconduct is of two principal kinds, the first being misconduct going to fitness to practise in the exercise of professional medical practice: *Remedy UK.* Most of the particulars admitted by Dr Reymond come within this first category.

104. Writing cheques for payment of tax or other charges is not connected to medical practice, so the Tribunal considered whether paragraph 4a(ii) could be described as morally culpable or otherwise disgraceful conduct. Conduct falls into the second category if it is dishonourable or attracts some kind of opprobrium, which may be sufficient to bring the profession of medicine into disrepute, whether or not directly related to the exercise of professional skills. Assisting Patient A by writing out cheques for her signature, to ensure timely payment to HMRC and other payees, is unlikely to attract opprobrium or condemnation from most people.

105. Dr Reymond's readiness to accept and remediate the gap in his knowledge of mental capacity is to his credit. His admitted deficiencies in record keeping, in relation to GP visits and financial issues, have also been remedied. Whilst such omissions ought never to have

happened, gaps in the records arose in the context of repeated visits to check up on Patient A. Dr Reymond visited twice a week for several years and recognises that he should have kept full, records at the time; he has never sought to justify his failure to refer to 'capacity' in GP records.

106. As to the conflict of interest, Dr Reymond said, through counsel, that his 'antennae should have been much sharper' after Patient A was discharged. By continuing as her GP, as well as a friend helping with financial affairs, he tried to do the best he could for Patient A who was 'desperate' to return home. He made a real effort to ensure that she could; his intentions are relevant.

107. Section 35C(2) of the Medical Act 1983 provides that fitness to practise shall be regarded as "impaired" by reason only of (a) misconduct or (b) … Action taken in good faith and for legitimate reasons, however inefficient or ill judged, is not capable of constituting [impairment by reason of] misconduct within the meaning of section 35 merely because it *might d*amage the reputation of the profession: *Remedy UK*.

108. The Tribunal accepts that Dr Reymond is genuinely remorseful about crossing the professional boundary which should have been maintained between Patient A and himself; he knows that he went 'too far'. He has sufficient insight to recognise that good intentions do not excuse his breaches. Whilst conflicts of interest are not always identifiable or avoidable, Dr Reymond accepts that he should have done more to remove himself from his vexed position as GP to a close friend.

109. Dr Reymond has demonstrated considerable insight, as he has recognised his errors and taken steps to remediate flaws and the lacuna in his knowledge. CPD included courses on record-keeping. Dr Reynold has considered where conflicts of interest could arise in other situations. If a conflict arose in future, he would need to declare it, seek advice if necessary, and then remove himself from any situation involving a conflict of interest.

110. The Tribunal took account of Dr Reymond's CPD certificates, reading list and personal development plan (PDP) which show that he has addressed the areas which are the subject of his admissions. There has been no other issue with his registration in a 26-year career as a GP. Dr Reymond has provided detailed testimonial evidence as examples of his professionalism.

111. Consultant Cardiologist, Dr Denis Pellerin, a colleague of Dr Reymond, said:

> 'He has always been both professional and knowledgeable regarding patients' requirements… We had telephone meetings discussing difficult cases. I have always worked in good collaboration and excellent communication with Dr Reymond for the benefit of patients throughout the years.'

112. One of his patients, Gersende Stoll, provided a testimonial saying that:

'Dr Reymond saved my husband's life in March 2019 as he diagnosed a heart attack that the A&E team at Chelsea and Westminster had missed'.

Despite the fact that emergency clinicians at the hospital did not so, Dr Reymond had measured the cardiac enzymes. His test results showed cardiac damage, and this required two coronary artery stents to treat the condition, which could have been fatal, but for his intervention.

113. In the context of his career as a whole, his good intentions, remorse for admitted breaches of GMP, insight and remediation, the Tribunal does not consider that Dr Reymond's failings amount to serious misconduct. The Tribunal accepted Mr Caplan's submission that Dr Reymond presents no risk to the public and a finding of impairment is not otherwise required in the public interest.

114. Dr Reymond has good insight into the need to keep medical records, avoid conflicts of interest and be aware of mental capacity issues now. There is no suggestion that he poses any risk to patients or members of the public. He has remediated as fully as he could, by way of continuing professional development, reflection and improved practice.

115. Testimonials provide strong evidence of his professionalism. Dr Reymond has admitted his failings, demonstrated remorse and insight into breaches of GMP. In view of these factors and his remediation, the Tribunal found that this misconduct is very unlikely to be repeated.

116. The Tribunal does not consider that the public would lose confidence in Dr Reymond, or in the profession's standards if his misconduct were to be deemed to leave fitness to practise unimpaired. The Tribunal has not concluded that a finding of impairment is necessary to affirm the standard of conduct expected of doctors.

117. Dr Reymond's admitted breaches do not amount to serious misconduct, in the exceptional circumstances of this case. In all the circumstances the Tribunal has determined that Dr Reymond's fitness to practise is not currently impaired by reason of admitted misconduct.

Determination on Warning - 12/08/2021

1. As the Tribunal has determined that Dr Reymond's fitness to practise is not impaired by reason of his admitted misconduct, it must now consider whether or not a Warning is required under section 35D(3) of the 1983 Act.

Submissions

<u>On behalf of the GMC</u>

2. Mr Atherton submitted that whether to impose a warning on Dr Reymond's registration is a matter for the Tribunal's judgement. He said that the GMC has no submissions as to whether or not a Warning is required. Mr Atherton added that the current interim order on Dr Reymond's registration must now be revoked.

On behalf of Dr Reymond

3. Mr Caplan submitted that a Warning is not appropriate, because there is no likelihood of repetition in this case and a Warning is not otherwise required. He agreed with Mr Atherton that the current interim order must now be revoked.

Advice from LQC

4. The Tribunal has approached the decision as to whether or not a Warning should be given in light of the following principles: Warnings indicate to a doctor that any given conduct, practice or behaviour represents a departure from the standards expected of members of the profession and should not be repeated. A Warning is a formal response from a Tribunal, in the interests of maintaining good professional standards and public confidence in doctors.

5. The recording of Warnings allows the GMC to identify any repetition of the particular conduct, practice or behaviour and to take appropriate action in that event. Breach of a Warning may be taken into account by a Tribunal in relation to a future case against a doctor or may itself comprise misconduct serious enough to lead to a finding of impaired fitness to practise.

The Tribunal's Determination on Warning

6. The Tribunal had regard to the legal advice it received and bore in mind the *Guidance on Warnings* (2021). In particular, it had regard to the section titled '*Factors to consider when deciding if a warning is appropriate'* and considered paragraph 32.

7. The Tribunal has already found that Dr Reymond's misconduct was ***not*** serious. However, his deficiencies in record-keeping for home visits to Patient A were repeated in the years 2011 to 2015. The Tribunal has determined that Dr Reymond's fitness to practise is not impaired by reason of his admitted misconduct. In these circumstances the Tribunal has to consider whether or not to impose a Warning.

8. The Tribunal has taken account of the following factors to determine whether or not it would be appropriate to issue a Warning.

a. There were breaches of paragraph 3g of GMP 2006 and/or paragraph 21a of GMP. This is because Dr Reymond did not make contemporaneous records of home visits, documenting any relevant clinical findings such as vital signs. However, he did record signs or symptoms of concern, making referrals as necessary to consultants, physiotherapists and others.

b. Dr Reymond's fitness to practise has not been found to be impaired by this Tribunal.

c. Any repetition of failure to keep contemporaneous records of home visits could result in a finding of impaired fitness to practise, but the Tribunal accepts that there is no likelihood of repetition.

d. There is no need formally to record any concerns because the Tribunal does not consider that there is a risk of repetition.

9. In deciding whether or not to issue a Warning the Tribunal has applied the principle of proportionality, weighing the interests of the public with those of Dr Reymond.

10. The Tribunal has taken account of a range of factors to determine whether or not a Warning is appropriate, including but not limited to:

a. Dr Reymond's full level of insight into his previous failings;
b. His genuine expression of remorse;
c. Dr Reymond's otherwise unblemished 26-year career as a GP;
d. Although the misconduct cannot properly be described as isolated because it persisted over time, there is no likelihood of repetition;
e. Testimonials and Dr Reymond's own evidence demonstrating that he is very unlikely to breach relevant GMC guidance in future;
f. Significant steps by Dr Reymond to remediate the previous lacuna in his knowledge of capacity;
g. Continuing professional development and reflection to ensure that he identifies and avoids future conflicts of interest and to maintain a good standard of record-keeping;
h. Dr Reymond has taken rehabilitative or corrective measures;

i. References and testimonials were provided by professional colleagues, such as a consultant cardiologist and pharmacist, who were aware of these proceedings, as well as patients whom Dr Reymond has treated.

11. The Tribunal applied the above guidance to the facts found proved and its determination on Impairment. It took account of the requirement for it to provide reasons for any decisions reached.

12. Throughout its deliberations, the Tribunal had regard to the statutory overarching objective. It bore in mind that its power to issue a Warning is central to its role in protecting the public, which includes protecting patients; maintaining public confidence in the profession; and declaring and upholding proper standards of conduct and behaviour. It also bore in mind the principle of proportionality, balancing Dr Reymond's interests with the public interest.

The Tribunal's Determination on Warning

13. The Tribunal did not consider that public trust in the medical profession or confidence in the regulatory process would be undermined in the absence of a Warning. It did not consider a Warning to be necessary to uphold proper standards in the medical profession.

14. The Tribunal did not consider that there is evidence that Dr Reymond's behaviour or performance has fallen below the standard expected to a degree warranting a formal response by the Tribunal. The Tribunal determined that it would not be proportionate in the unique circumstances of this case to impose a Warning.

15. Therefore, the Tribunal determined not to issue a Warning in accordance with Section 35D(3) of the Medical Act 1983 and Rule 17(2)(m).

16. The interim order currently imposed on Dr Reymond's registration is revoked.

17. That concludes this case.