Professional conduct

Part 1 - The law

In the first of three articles, **David Cartwright** looks at regulation and guidance against which optometrists and dispensing opticians practise. Subsequent articles will look at what registrants should do to comply with the regulation and what can be learnt from actual case histories

PROFESSIONAL CONDUCT

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The competencies for all optical registrants include: 'the ability to comply with legal, professional and ethical issues relating to practice and the ability to work within the law and within codes and guidelines set by the regulator and the profession'. Therefore it is important that registrants have a clear understanding and awareness of these issues and what they need to do to comply in order to properly serve their patients and maintain registration.

Professional practice

The term 'professional' is often widely used to denote a high quality of work or service and in the sporting world to differentiate between the paid and the amateur who is unpaid. However, if we look to the more traditional view of a profession, there are a number of common attributes including:

- High standards of ethics
- A professional body
- A regulatory body
- Education to give expertise in that role and formal qualifications
- Ongoing education
- A degree of autonomy to exercise professional judgment
- Protected function
- Putting the interests of the client above their own interests.

A professional enjoys a protected function as only they can perform certain tasks. This generally confers a perceived elevated status in society and higher earnings. However, a profession as a whole is judged on its individual members' actions and with this privileged position comes responsibility to act in a professional manner. If professional responsibilities are not met, standards of service fall and the trust of members of the public is lost, leading to loss of the protected function. Our regulations, codes of conduct and professional guidance remind us of our responsibilities to our patients, our profession and our future.

The Act

Before 1958, optometry and dispensing optics were not regulated professions, but in the early 1950s a committee under chairmanship of Lord Crook suggested that the key aims of an optical act should be to:

- Establish a statutory registration body, known as the General Optical Council
- Maintain registers

Rex Features

A profession as a whole is judged on the actions of its individual members

- Set standards for education
- Restrict who can test sight and dispense and the use of titles
- Exercise disciplinary powers.

This led to the Opticians Act 1958, which sets the legal framework for the practice of optometry and dispensing optics in the UK. The legislation was consolidated in 1989 to incorporate a number of changes that had occurred over the first 30 years, such as unregistered dispensing, to form the 1989 Act. Further amendments were added, including the introduction of mandatory Continuing Education and Training (CET) to form the Opticians Act 1989, amended 2005. In addition there are additional rules and regulations in relevant areas where the General Optical Council has exercised its powers within the Act, subject to approval by the Privy Council.

The Opticians Act is divided into various parts that set out the regulation against which the General Optical Council regulate optical practice. As with much legislation it is written in 'legal language' and can be difficult to follow. The aim of this section is to set out simply the key points of the act; however, it is outside the scope of this article to go into each of the parts of the Act and the functions of the GOC in detail.

The General Optical Council

Part 1 of the Act sets out that there will be a regulatory body known as the General Optical Council (GOC) with 'the general function of promoting high standards of professional education, conduct and performance among registrants and additional functions assigned through the Act', in order to protect, promote and maintain the health and safety of members of the public. In line with the original aims of the Act, the GOC has four core functions:

- Setting standards for optical education and training, performance and conduct
- Approving qualifications leading to registration
- Maintaining a register of individuals who are qualified and fit to practise, train or carry on business as optometrists and dispensing opticians
- Investigating and acting where registrants' fitness to practise, train or carry on business is impaired.

Following recommendations within the government white paper *Trust, assurance and safety – the regulation of health professionals in the 21st century*, that Councils will become smaller and more 'board like', the GOC was reconstituted in 2009 to a Council of 12 members, with equal number of lay and professional members. The Council normally meets in public with agendas papers being published in advance of the meeting.

The Council has seven main committees. The Audit and Remuneration Committees are populated by Council members; however, Council members no longer sit on the remaining five committees.

These committees generally meet three times a year, depending on the business to be transacted and are made up of a combination of professional members, who have an optical qualification and lay members, who do not.

The Education Committee advises the Council and other committees on optical training, education and assessment. This includes the approval of training establishments and qualifications. It reviews requirements for the content and standard of education, including the CET scheme, and recommends changes as necessary.

The Companies Committee advises on matters relating to business registrants.

The Standards Committee advises on the standards of conduct and performance expected of current and potential registrants.

The Registration Committee advises on registration issues, including the rules governing registration and publication of the registers.

The Investigation Committee investigates allegations that the fitness to practise or train, of a registered optometrist, dispensing optician or student, is impaired. In the case of a business if the fitness to carry on business is impaired. The committee decides whether an allegation should be referred to the FTP Committee, or an alternative course of action taken. There must be at least five members present, including one optometrist, one dispensing optician and one lay member, in order for the committee to make decisions about complaints. The Investigation Committee meets in private.

In addition to the seven committees there is also the FTP Committee for the purpose of inquiring into and determining allegations relating to the fitness to practise of registrants. This committee is made up of lay people, optometrists and dispensing opticians, (currently 36 listed on the GOC website), from which a maximum of five people are selected to serve on the Fitness to Practise Hearings Panel. In every case against an optometrist or a dispensing optician, there will be a lay majority. Both lay and professional members of the hearings panel are independent of the GOC. Panel members are appointed for a term of five years, with the option to serve for a further five years on application.

Registration

Part 2 deals with registration of optometrists, dispensing opticians, students and corporate bodies. To undertake activities restricted to each role, individuals must be registered with the GOC.

Each registrant has a unique registration number with the initial prefix defining which category the individual or business sits:

O1 – optometrist
DO – dispensing optician
CO – company
SO – student optometrist
SD – student dispensing optician.

Some dispensing opticians are also on a specialist register which allows them to fit and supply contact lenses. The register is available for anyone to view through an online search facility of the GOC website.

Before joining the register, all optometrists and dispensing opticians, including students, are required to have completed, or currently be studying for a GOC-approved training course. They must meet certain standards of education and performance, and comply with the GOC code of conduct.

Registrants have to provide a health declaration, plus details of any criminal convictions, cautions or investigations, or disciplinary proceedings which have been taken against them or are currently pending. Full registrants must also hold professional indemnity insurance and show that they have completed the minimum required CET.

If a registrant fails to comply with these requirements the registrar may refuse to register their name, refuse to retain or restore their name, or remove their name from the register.

In the case of a corporate body registration, the majority of directors need to be registered optometrists or dispensing opticians or alternatively, the business must have been included in a health service ophthalmic list before 1957. If the greater part of a corporate body's business is non-optical activities, then the optical services should be under the management of a registrant.

CET

Part 2 also gives the GOC the power to make rules for registrants' CET. CET is a statutory requirement for all fully qualified optometrists and dispensing opticians to stay on the register. The three-year cycle beginning January 1 2013 requires registrants to:

- Gain 36 points
- Gain one point through peer review
- Undertake CET across all competency areas
- Undertake more than one type of CET activity
- Spread CET activity throughout the three-year CET cycle
- Contact lens DOs will need to obtain 18 of their 36 points in CL-approved CET.

Details of the new scheme have been circulated to all registrants and have been widely reported in the optical media (See *Optician* 11-01-13, page 12).

Education and training

The final sections of part 2 of the Act deal with education and training.

The Council sets the competencies, the knowledge and skills that an optometrist or dispensing optician must be able to demonstrate in order to be granted a qualification. The core competencies are divided into four areas of practice: optometry, dispensing optics, contact lenses (for dispensing opticians) and therapeutic prescribing (for optometrists). There are many of the competencies that are common to both professional groups, with other competencies being specific to that function.

The Council also sets the content and standards of education and training required to achieve those competencies leading to registration. The Council approves courses and qualifications and will then carry out visits to education and examination bodies to check they are maintaining and improving standards.

Investigating

Part 2A of the Act deals with the GOC's fitness to practise powers and process. This part needs to be considered together with fitness to practise rules made by the GOC. In addition the GOC issues helpful guidance for registrants and members of the public on how the Investigation Committee and FTP Committee operate and make decisions.

The grounds on which fitness to practise of a registered optometrist or dispensing optician are impaired may be:

- Misconduct
- Deficient professional performance
- A conviction/caution for a criminal offence
- Adverse physical or mental health or a finding by another health/regulatory body.

For a business registrant the grounds for which fitness to practise may be impaired are similar with the addition of impairment due to practises or patterns of behaviour that the registrant ought to have reasonably known or has ▶

instigated and amount to misconduct.

Misconduct implies a serious breach which indicates that the registrants' fitness to practise is impaired. A one-off negligent act is unlikely to constitute misconduct, unless very serious. Multiple acts of negligence or omission may constitute misconduct.

Deficient professional performance implies an unacceptably low level of performance, normally based on looking at a fair sample of the registrant's work. Again a one off example of negligent treatment would be unlikely to constitute deficient professional performance, unless very serious.

Following receipt of an allegation, (in the Act a complaint is referred to as an allegation), against a registrant, it is referred to the Investigation Committee. In undertaking its investigation the committee can ask for further information such as a health or performance assessment of the registrant, before it reaches a decision. The committee may require the registrant to supply any information relevant to the complaint and will also want details of the registrant's employer. The employer and any other person where the committee consider it to be in the public interest will be told there is an investigation of the registrant's fitness to practise.

The committee will then decide if the allegation should be considered by the FTP committee. In doing so it takes into consideration whether there is a realistic prospect of establishing that the practitioner's fitness to practise is impaired to a degree that justifies action being taken against their registration. This is known as 'the realistic prospect test'. The committee will consider well supported mitigating factors, which means there is no likelihood of the FTP finding there is impaired practise, and will also consider if the practitioner's admitted failing is capable of being remedied, and/or has already been remedied.

It will be reassuring for registrants to know that only a minority of the complaints considered by the Investigation Committee are referred to FTP. In the majority of cases, the Investigation Committee decides there is no need for any further action to be taken, or the complaint can be appropriately dealt with by issuing the practitioner with a warning. This warning is in place for four years, but is not publicly available. The committee may also suggest the registrant attend a performance review with the College of Optometrists or the Association of British Dispensing Opticians. The Committee has no legal power to enforce this, but hopes the registrant would take advantage of the opportunity to learn.

Rex Features

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The Investigation Committee takes its decisions by a simple majority vote and no committee member may abstain from voting. Where the votes are equal, the committee must decide in favour of the practitioner. The chair does not have a casting vote. When making its decision about a complaint, the committee will consider all evidence received, but also any written representations that have been received from the practitioner concerned. The committee will also consider any comments received from the complainant (made once the complainant has seen any written representations made by the optician). Any comments from the complainant are also copied to the practitioner.

The Investigation Committee is also required to consider whether the FTP Committee should consider making an interim order suspending or placing conditions on the registration of any optician who is the subject of a complaint. The Investigation Committee may instruct the GOC to refer a complaint to the police if it appears to relate to a criminal offence, or to refer the complaint to another enforcement agency, as appropriate.

Finally if no further action is to be taken, all parties are informed and the Investigation Committee may give advice on future conduct such as handling of dissatisfied patients. Throughout the process all parties (complainant, registrant, employer) are kept informed as to what is happening and will be aware of the committee's decision and the reasons for that decision.

Fitness to practise

It is important to consider the background against which the FTP panel operates. The public is entitled to a good standard of care as befits a professional service where there is a protected status. Registrants must be safe and competent to practise and maintain proper relationships with patients and colleagues. If there is an issue of competency or conduct, it is reasonable that the professional does not work in unrestricted practise. In addition the FTP panel must consider the reputation of the profession.

The FTP panel has to consider whether the decision it is making protects the public and the confidence in the profession. The members of the panel exercise their own judgment in making decisions, taking into account the standards of good practise the GOC has established.

The standard of proof applied by the FTP panel is the standard applicable to civil proceedings, that is proof on the 'balance of probabilities'. This was a change in 2008, before which the criminal standard of proof was used, that is 'beyond reasonable doubt'.

Where an allegation against a registrant is referred to the FTP committee, once the committee has heard the evidence it must decide if the facts are proven. Then on the basis of the facts proven whether the registrant's actions amount to misconduct, deficient professional performance, or that he or she has adverse physical or mental health, and if any of these lead to a finding of impaired fitness to practise. The decision on impairment is a separate decision from whether there is misconduct. Finally it is for the committee to decide what sanction there should be, if any.

There are a number of sanctions or directions possible:

- The registrant's name can be erased, (except in health cases)
- The registrant can be suspended for up to 12 months
- The registration is subject to conditions for up to three years
- In addition to the directions, the FTP committee has the power to impose a financial penalty, up to £50,000 (except in health case).

The committee considers sanctions in descending order and the sanction should be proportionate.

Where it is found that the registrant's fitness to practise is not impaired, the FTP Committee can still issue a warning regarding future conduct of performance. A warning may be appropriate in certain circumstances such as there is no evidence of patient harm, there is early admission of the facts, it is a one-off event, there is genuine regret, previous good character or steps have been taken to correct behaviour. The warning does not affect

the registrant's ability to practise, but is published on the GOC website and will be disclosed to anyone who enquires about fitness to practise history.

The FTP Committee also has the power to immediately suspend registration for up to 18 months where it is viewed that this is necessary for the protection of the public or in the registrant or public's best interest. An interim order can suspend a practitioner from practise completely, or temporarily remove an entry relating to a speciality or proficiency, or it can make their registration conditional on compliance with requirements imposed by the committee. An interim order can only last for a maximum of 18 months, (unless extended by the relevant court), and will be subject to regular reviews. These decisions will only be used where there is a real present or future risk to members of the public and can be made without the registrant being present. Hence there needs to be clear evidence of risk as the registrant is not there to defend himself.

The FTP committee may take into account mitigation evidence, which can include testimonials about previous good character, the time lapsed since the incident, remorse, demonstration of understanding the concerns and actions taken to address concerns.

Any registrant who has been erased from the register can apply to be restored, but not until two years after erasure. The appeal is heard by the registration appeals committee, who may require evidence as to the appellant's fitness to practice.

It is perhaps comforting to the registrant to know that there are many checks and balances in place such that the investigating committee/FTP has to make many considerations through the process that makes the process 'fair' to the registrant. An example is that there is a public interest in opticians not being harassed by unfounded complaints.

At each point in a case the FTP Committee must explain the reasons for its decisions and so all parties are able to see the why a course of action has been taken, even if they disagree with that action.

Rex Features

Only a registered optometrist, medical practitioner or dispensing optician may fit a contact lens

Proceedings and appeals

Part 3 of the Act deals with how notifications are served, proceedings within FTP and Registration committees, appointment of legal and clinical advisers and making an appeal against a FTP decision.

Restrictions on sight testing, CL fitting, sale of optical appliances, use of titles

While all of the Act is relevant to registrants, part 4 of the Act in particular deals with everyday aspects of our everyday business.

The Act states that only a registered optometrist or medical practitioner can test the sight of another person, (testing sight being the term used in the original 1958 Act). There is an exemption for students who are training.

In the sight test, it is the duty of the optometrist to perform an examination of the external surface of the eye, an intraocular examination and such additional examinations as appear to the clinically necessary. It is also a duty to give a written statement that the examination has been carried out, whether referral to a medical practitioner is required and a signed written prescription. Following the sight test, a fee can be charged, but not before.

Only a registered optometrist, medical practitioner or dispensing optician may fit a contact lens. To do so they must have a prescription from a sight test that is less than two years old on the date the fitting begins or the fitting begins before a specified re-exam date on the prescription. On completion of the fitting the patient must be given a signed written specification that would enable the lens to be replicated. The specification should state an expiry date. The fitter should also provide instruction on the care and wearing of the lens.

Part 4 covers the sale and supply of optical appliances, (contact lenses and spectacles), which cannot be sold unless by or under the supervision of a registrant. However, there are a number of exemptions to this.

Due to the sale of optical appliances order 1984, unregistered dispensing of prescription spectacles is possible, to anyone who is over 16 and not registered blind or partially sighted. The unregistered seller must have a signed written prescription that is dated within two years. The seller should also verify the prescription of the spectacles with a focimeter and that the optical centres align with the centre of the customer's pupils.

A contact lens can also be sold by an unregistered person with the caveat that they are under the general direction of a registrant. In this case the seller should have the original specification or a copy that is verified with the person who provided it and the sale must be made before the expiry of the specification. The seller must make arrangements for the patient to receive aftercare.

Finally 'ready made readers' can be sold as long as they have equal lens powers of less than 4D. They should be only for presbyopia and not sold to under 16s.

Part 4 then deals with registration. It is an offence under the Act for an individual to take or use the titles of ophthalmic optician, dispensing optician, optometrist, registered optometrist or imply registration, when they are not registered. For a body corporate the same applies to the use of the titles of ophthalmic optician, optometrist, dispensing opticians or registered optician.

Rules

The GOC is able to make rules through powers granted to it in the Act.

The rules relating to Injury or Disease of the Eye 1999 state that where a registered optometrist or dispensing optician suspects a patient consulting him is suffering from an injury or disease of the eye, that patient should be referred to a medical practitioner. The registrant should advise the patient to consult a medical practitioner, give a report to the practitioner indicating the grounds for referral and if urgent inform the practitioner immediately.

An exception to the rule to refer to a medical practitioner is that a registrant can also refer to a person other than a medical practitioner if that person has the appropriate qualifications or expertise to provide medical treatment. A dispensing optician may refer to an optometrist. In both these examples the registrant should be satisfied that the referral to someone other than a medial practitioner is appropriate in the circumstance.

If the patient is unwilling to consult a practitioner, the registrant should record this and the reason for the unwillingness. If the registrant feels it is not necessary to refer (eg there is a cataract that is known about and is not ready for surgery) the optometrist should explain to the patient the reason for not referring, make full notes of the action taken, the reason and their management.

The code of conduct

In addition to setting standards for the knowledge and skills that a registrant should have, the GOC sets standards for good practice and professional conduct to which registrants must adhere. This is within the two separate codes of conduct for individuals and businesses. The code states that if a registrant fails to comply with the duties and responsibilities set out in the code, they are putting their registration at risk. The individual code has 19 points. Examples are:

- Recognise and act within limits of your competency
- Give patients information in a way they can understand and make them aware of options available
- Ensure your conduct, whether or not connected to your professional practice, does not damage confidence in you or your profession.

The code states that registrants should also inform the GOC immediately if they have been convicted of a criminal offence or accepted a caution, have been barred from working with children/vulnerable adults, disciplined by a regulatory health or social care organisation or have impaired fitness to practise. Registrants are also instructed that if they have information about themselves or other health professionals which suggests they are not safe to practise, they should take action to protect patients. In the first instance this should be at a local level, but if this fails or the issue is very serious the GOC should be informed.

The code reminds registrants that detailed guidance and standards are produced by other bodies, such as the College of Optometrists, the Association of British Dispensing Opticians or NHS bodies. It is expected that registrants are familiar with these and comply with local and national standards. The GOC says that reference may be made to the guidance and advice of other bodies in the exercise of GOC functions such as determining fitness to practise.

Professional body guidance

The College and ABDO issue guidance. This represents the bodies' view of good practice, in the case of the College Council, 'what a competent optometrist is able to do in practical and achievable terms and within existing training and skills'. ABDO reminds members that 'they must maintain a high standard of behaviour, integrity and competence, bringing to bear all their knowledge, skill and expertise in serving the public'.

Both professional bodies divide their guidance into sections that address conduct, ethics and clinical practice. Registrants should remember that there is a common-law duty to practise to the same standard as a reasonably competent dispensing optician or optometrist and so there should be a valid reason not to follow the guidance.

NHS regulations

There are obligations under NHS regulation when supplying General Ophthalmic Services, either as performers or contractors. It is outside the scope of this article to go into detail here, but registrants must have an understanding of NHS regulation. Examples include:

- You will be asked to provide references to a contractor for whom you provide services
- You must register on the ophthalmic performers list (in England)
- Keep full, accurate and contemporaneous records
- You should be aware of the conditions that govern the supply of sight tests and optical appliances, eg intervals between sight tests.

USEFUL WEBSITES

www.optical.org
www.college-optometrists.org
www.abdo.org.uk

Summary

To maintain registration and be able to practise, an optometrist or a dispensing optician must follow the regulation that governs their work and also be aware of their position as a professional, with the obligation to maintain standards in public and private life.

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Professional conduct

Part 2 - Compliance

In the second of three articles, **David Cartwright** outlines the guidelines that should be followed to make sure a practitioner is working within the law

This article looks at what registrants need to do to comply with the regulation and guidance against which they practise. This is not an exhaustive review of all the factors a registrant should take into account, but it picks out some of the key issues and highlights common errors that are made.

Part 1 in this series (18.01.13) looked at the regulation and guidance that governs the practise of optometry and dispensing optics. Perhaps one of the greatest worries for practitioners is the prospect of contravening the regulations and putting their registration at risk. Hence it is important to understand the factual background and to be aware of what is required. Thus in the unlikely event of a problem the practitioner is able to defend their work and demonstrate appropriate actions were taken.

The competencies for all optical registrants include: *'The ability to comply with legal, professional and ethical issues relating to practice and the ability to work within the law and within codes and guidelines set by the regulator and the profession.'*

Professional practice

It is important to remember that as a professional we are judged by the actions of individuals and we must maintain high standards to maintain public trust and our professional status. A professional body is one feature of a profession and supporting the Association of British Dispensing Opticians and the College of Optometrists through membership means that the optical professions will continue to have high standards and advance their professional position.

Registrants should understand that their professional and public lives are linked. While no one should commit an illegal act, it may be a greater deterrent to realise that this can seriously impact your livelihood through suspension from the register. Although rare, there have been cases where a registrant has committed a 'petty' criminal act, such as theft of relatively small amounts of money. This may be out of character and a momentary lapse. However, when the crime is reported to the General Optical Council, either through the police or by the employer, the consequences for the individual are severe and greatly outweigh any gain from the initial act.

Record-keeping

We are frequently told about the importance of good patient record-keeping and this is highlighted in General Ophthalmic Services (GOS) regulations and the GOC code of conduct. Failure to keep adequate records may constitute serious professional misconduct. The importance of records is also emphasised in the College of Optometrists and ABDO guidance, who 'considers it an essential part of practice that practitioners keep good clinical records'.

Records should show you did what was expected and acted reasonably

Records are an important tool to help give our patients an excellent level of clinical care at each visit. They allow for continuity of care from one visit to the next through monitoring progression and trends and passing information to colleagues. There is also the defensive aspect to records in that they can show you did what was expected and acted reasonably in your treatment of a patient. In the face of civil proceedings or a GOC investigation, good records will minimise the chance of a case proceeding and greatly increase the chance of a successful defence if it does. In these cases a good record gives the practitioner greater confidence that they are able to defend themselves and minimise anxiety during the period of time between notification of the complaint and resolution. This can take time – perhaps years – and the effects on the practitioner should not be underestimated.

If a serious problem occurs, there appear to be a number of common root causes that good use of records would overcome. These are:

- Previous record were not reviewed
- Signs and symptoms pointed to dilation, but this was not done
- The tests conducted within the eye examination and advice given do not match the presenting history and symptoms, leaving unexplained findings
- Communication of findings with patient was not recorded
- Speed of referral was not recorded.

Many optometrists will admit that their record card keeping could be better. Over the years the peer view has changed, many still only record positive findings and very often time is cited as a barrier to greater compliance. Whatever the reason, all practitioners should be clear that it is their responsibility to maintain contemporaneous records, consistent with current good practice, from every clinical interaction.

From your records it should be clear to you and to other practitioners what has happened during the examination, so that there is seamless patient care from one visit to the next. There are some basic principles we should adopt when thinking about record card completion.

- Records should be available at all times
- It is useful to have a standardised structure and layout
- Entries are made in chronological order, with all entries being dated
- It should be clear who has made the entry and in the case of a delegated function or student under supervision, who was the responsible person
- All interactions with patients, by you and others, (outside the eye examination), should also be recorded
- Entries should be contemporaneous, ie made at the time of the action undertaken. Any alterations or deletions should be signed and dated
- Entries should be legible
- Abbreviations may be used that are clearly understood by other practitioners.

The College of Optometrists guidance sets out 'what a competent optometrist' should be recording within a routine eye examination.

History and symptoms

- Reason for visit
- Symptoms – description and duration
- General health
- Medication
- Family history
- Occupation (including VDU use)
- Driver? (with or without Rx)
- Previous optical prescription and date of last eye examination.

Clinical examination

- Unaided vision and/or vision with habitual Rx R and L
- Ocular muscle balance and method (at least cover test) for distance and near with habitual Rx
- External examination – preferably using a slit lamp
- Internal examination (with or without dilation – if dilation is used, which drug and concentration, batch number and expiry date)
  - Media status + diagram of opacities if appropriate
  - C/D ratio R and L and any unusual features
  - A/V ratio R and L and any unusual vessel features (eg nipping, irregular calibre)
  - Macular status R and L
  - Diagram of any fundal lesions.

Refraction

- Subjective refraction (if cycloplegic used, what drug and concentration) with VAs R and L
- Reading addition with reading VA binocularly or individually if appropriate
- Ocular muscle balance and method (at least cover test) for distance and near with new Rx if appropriate (eg. significant change)
- Fixation disparity if appropriate (eg symptoms or deviation on CT) – state method used
- Prescription given for each task (driving, VDU etc) and any associated reasons (eg to help headaches, to try and improve OMB etc).

Miscellaneous

- Recall date and reason if early recall suggested
- If the patient was referred and what for. A copy of the referral letter should be kept with the patient record
- If a notification letter was sent to the GMP. It is advisable to keep a copy of the notification letter with the patient record
- What advice was given to the patient (eg to drive with spectacles etc).

The following items may be included

- Near point of convergence
- Ocular motility assessment
- Pupil reactions
- Objective refraction results (autorefractor and/or retinoscopy)
- Details of any written information given to the patient
- Fundal or other imaging IOP if appropriate – method and time of readings. Note individual readings if appropriate
- Visual field examination if appropriate – type of field screener used, which programme, what brightness (if not automatic) and what correction the patient was wearing. A printout of any abnormal results would be desirable
- Repeated tests to eliminate spurious results.

ABDO suggests recorded information should include

- Full name, address and daytime telephone number
- Date of birth
- Occupation (necessary knowledge for giving advice and guidance in dispensing spectacles)
- Recreation (for the same reasons as occupation)
- GP's name and address
- The prescription
- Measurements, tints, coatings etc, facial measurements and centration distances
- Details of any other services provided – ie low vision aids
- Charges and fees.

There is frequent discussion in professional circles, including optometry, whether it is necessary to record everything for everybody, irrespective of the individual patient features. The argument against is usually that if you visit the GP with an injured leg, he will not examine your head. In our case, however, the patient is attending an eye examination to ensure they are seeing well and their eyes are healthy, hence there are a number of investigations required. It is very useful to have the College list in mind, but this should not encourage practitioners to follow a list without considering the features of the patient as an individual. The record should show your thought processes in caring for the patient at each visit, that you understand their individual risk factors, and that you completed the appropriate investigations and gave reasonable advice. If you have not noted down the results of a test, it is assumed you have not carried it out.

Before commencing the examination it is sensible to look at previous records and to review what has happened before. Patients expect this continuity and while a test result from the current examination may be within normal limits, there may have been a change from the last visit that indicates further investigation.

In addition to the 'standard' questions such as general health and medication, the initial symptoms and history should clearly outline why the patient has attended and the key issues that are important to them about their visit. More detailed questions may follow appropriate to that patient. For instance, if a patient's occupation is driving, it would be sensible to enquire further to consider visual requirements.

The tests recorded will show that you have ensured the patient's eyes are healthy and can see well, and should demonstrate you have conducted appropriate tests to investigate further lines of thought following from the patient's presenting symptoms and history and risk factors. One common error, highlighted by a number of civil cases, is the failure to dilate and record this when seeing patients with high myopia or presenting with flashing lights and floaters.

You should record both positive and negative findings. This will be important when investigation is required to exclude the presence of a condition. As an example, your 'normal' description of the retinal periphery may be recorded as flat. However, with a high myope, your record should show greater detail of retinal investigations, for example dilation and that you have not seen any holes, tears and the periphery is intact. This demonstrates that you have understood that the patient is more at risk of retinal degeneration and you have investigated this.

In completing records, wherever possible, you should describe your findings, rather than use tick marks. It is acceptable to use standards phrases, such as 'periphery intact', to describe a normal appearance. This author also believes it is acceptable to describe one eye and then to record the other eye as the same. However, where there is a difference to the normal, or the test/observation is a key aspect of the patient's care, this should be described in words for both eyes, (even if the same), and with a diagram/photograph if possible. This shows that the individual patient has been considered rather than a blanket set of descriptions used.

It should be possible for a practitioner to be able to demonstrate from a range of records that non-standard descriptions ▶

are used. This can counter any suspicion that investigations are recorded without being done. In addition, we all have to accept human error at times, and consider an example where an investigation is done, but the record card is not completed. In the unlikely event of a complaint, the practitioner should be able to demonstrate from other records it is their normal practice to complete the investigation, but in this case it is a one-off error of recording. Although clearly not ideal, a one-off omission is not likely to be misconduct.

Advice given should be recorded. This may be simply what the spectacles are for, whether there has been a change or when the next examination is due. For a patient who has presented with floaters but no problem found, you should record advice given on the symptoms of detachment and what to do. If you have referred the patient you should clearly note the required speed of referral.

Time spent at the end of the examination using the record card is well spent. Considering the record will show if you have addressed the patient's symptoms and history and risk factors and given appropriate advice. You will also be able to see if there are any anomalies on the record, for which you have not found a reason. For example, if one eye has reduced acuity there should be a reason for this identified on the record and, if not, further actions taken.

The end of the examination is the final opportunity to consider the critical elements of the patient's care and whether these have been appropriately managed. If there is going to be a challenge at some time in the future, what is likely to be the issue, and would you be able to show that you have done what was required? If the patient is at risk from a particular condition, have you excluded that? If the patient declines advice given this should be noted on the record. For instance, an African Caribbean patient presents who has a family history of glaucoma. Your record should show that you understand this means the patient has a greater risk of developing glaucoma and you have done appropriate tests to exclude this, such as applanation tonometry, more detailed description of the discs, anterior angle and full threshold fields.

Considering what are the critical issues in a patient's care is a technique that other professions use and is something that optical practitioners can adopt.

Any accompanying material, such as referral letters should be kept with the card. With new technology, such as retinal photography, the information is held electronically. In this case it would be advisable to note on the record that an image has been seen and to record key information from the image, (eg CD ratio), on the record. Of course arrangements must be made to ensure electronic data is secure and is backed up.

The AOP recommends practitioners retain adult patients' records for 10 years following the patient's last visit

The principles and good practice that apply to paper records will equally apply to electronic records. Electronic records will have the advantage that there can be prompts and reminders to input essential information and ambiguous entries can be highlighted, for instance a plus prescription entered for one eye and minus for the other. There is also the advantage that standard phrases and grading scales can be built into the system and retrieved at the click of a button. However, this may present a disadvantage that practitioners need be aware of – that is automatically entering information without thinking about whether the test has been done. Again it would be useful to be able to show that non-standard phrases are used.

Records are covered by the Data Protection Act. A patient or someone acting on their behalf is able to access their records. The patient can be required to place the request for access to the records in writing. The practice may charge a fee for copy of the records and are allowed 21 days to provide records where the exam took place, within 40 days or 40 days for earlier records. In the circumstance where a patient is requesting a copy, practitioners should ask themselves why the patient wants the copy and what is the likely impact of charging and withholding information for up to 40 days. It is likely that the patient has an issue with their treatment and something the patient sees as an unnecessary delay may inflame the situation. It may be wise to provide the copy quickly without charge and offer that anything unclear or abbreviated can be explained.

The current College guidelines suggest records should be kept for a minimum of eight years for adults, or until the age of 25 if the patient was 17 at conclusion of treatment. The AOP recommends that practitioners retain adult patients' records for 10 years following the patient's last visit and for minors, until the patient's 25th birthday.

Clinical governance

Clinical governance is the system through which organisations and individuals continuously monitor and improve the quality of their care and services, safeguard high standards of care and services and create an environment where excellent patient care will flourish. It is therefore key to delivering great service to patients and is a requirement of the GOC code of conduct, professional guidance and the NHS. All registrants and contractors should be aware of their responsibility to undertake clinical governance.

The Association of Optical Practitioners, The Federation of Ophthalmic and Dispensing Opticians, ABDO and the College have jointly developed a clinical governance and contract compliance framework for England and Wales. Entitled 'Quality in Optometry' (QIO); it is available on the web. The framework has been based on the NHS 'Standards for Better Health', but has been developed specifically for optometry and dispensing optics and so contains relevant checklists, audits and links to reference material for both contractors and practitioners.

This is an excellent tool for registrants to ensure they are up to date with clinical governance issues. Referring back to the record-keeping section of this article, the QIO record audit is particularly useful for practitioners to assess their record-keeping and to keep a regular check that standards are being maintained.

NHS contract

The QIO framework also will enable contractors and practitioners to be aware of what is required to comply with their NHS contract and to prepare for a contract compliance visit. Failure to comply with contract terms can lead to notice being given meaning that it would no longer be possible to provide GOS services.

PCTs will from time to time audit claims made from each practice and have a legal right to inspect records relating to claims. This is to check that claims are valid. Each registrant will be required to keep clear records that can show you were practising correctly against guidance for the issue of vouchers and claiming eye examination fees. This means that it must be clear why a particular course of action has been taken.

Registrants would be advised to read

the guidance, 'Making Accurate Claims', issued by AOP, FODO and ABDO, that will help contractors and practitioners understand what is required.

Registrants should be aware that they are only able to undertake an eye examination under GOS in England if they are on the Ophthalmic Performers List of a primary care trust in England. (Being on a GOS list in Wales, Scotland or Northern Ireland does not allow a practitioner to perform GOS in England – and vice versa). If the registrant is on a performers list in one area they are then able to perform eye examinations in any other PCT. However, if a performer has not conducted an eye examination in the PCT's area where they are listed for a year, the PCT is able to remove the performer from the list. The PCT should notify the performer that this will happen. A problem sometimes arises when the notification does not reach the performer and the performer is then practising without a current PCT registration. Any NHS eye examinations undertaken in this time may be claimed back and the performer is not allowed to do GOS work before relisting elsewhere and this may take several weeks. Performers are advised to be on the Ophthalmic Performers List of the PCT where they do either all or most of their GOS work.

Registration

Each year every registrant is required to renew their registration with the GOC. Notification of this is sent to all registrants at the beginning of the year for the deadline of March 15. Registrants are then able to complete the process online. Payment of the registration fee is by cheque, bank transfer, credit card or direct debit.

As part of the renewal process, registrants make declarations about any criminal convictions or cautions, disciplinary proceedings by a regulatory/health body and any mental/physical health conditions which may affect ability to practise. Individual registrants must also confirm they have professional indemnity insurance. This year individual registrants will have to achieve the required number of CET points for the cycle ending in December 2012. Going forward, individual registrants will be required to gain points each year across a variety of competencies. Practitioners should not follow a route of randomly gaining points, instead preferring to look at their individual development and learning needs. A good way to manage this is through the College of Optometrists' personal development plan toolkit.

Any registrant who does not pay the retention fee and submit an application is removed from the register. It should be noted that this means they cannot practise as an optometrist or dispensing optician. Further their names are circulated to primary care trusts, health boards and employers who have registered to receive the information. If the registrant has continued to practise in error, NHS fees can be reclaimed. This has happened and the cause often seems to be that the registrant assumes that paying the fee is all that is required if their details have not changed. This is not the case and everyone needs to be aware that it is their responsibility to ensure registration is completed.

Professional indemnity

As already stated, a requirement of registration is to have professional liability insurance which protects patients by providing insurance cover against claims arising from allegations of clinical error, negligence or malpractice. It also protects practitioners and practices against the costs of any such claims or allegations, by providing cover for the costs of legal defence. The two largest schemes most commonly used are those run by the AOP and FODO, although ABDO also provides insurance for individual DOs.

Broadly, both the AOP and FODO schemes provide up to £5m insurance cover for claims across the range of actions that may be brought against optical businesses, practitioners and non-registrant colleagues. This includes professional liability and legal defence cover for disciplinary investigations before the GOC, and NHS boards.

As with any insurance it is always wise to check that the detail meets your particular requirements and circumstances. A problem that has arisen in recent years is that of practice owners relying on their optometrists' or OMPs' professional liability insurance which of course leaves the practice exposed if a claim is made against both a practitioner and the practice owner, which is now often the case.

The AOP cover for individual AOP members is focused on protecting them and their reputation and right to practise. Members are covered on a 'claims-made' basis, which covers any claim that is made during the period of membership, no matter when the event that gave rise to the claim occurred. If a member leaves the AOP they will no longer be covered and need to remember to take out 'run-off' cover.

FODO cover is an a 'claims occurring' basis which means that the insurer, at the time of the incident giving rise to the claim, (in this case FODO) deals with the claim and so there is no need for run-off cover if a person leaves the scheme. FODO cover is for individual optical professionals and optical businesses of all sizes (including blanket cover for all staff on an unnamed basis). FODO also offers retrospective cover to new members joining the scheme.

Supervision

Our legal framework states that only a registered optometrist or medical practitioner is able to conduct an eye examination and only a registrant is able to dispense to under-16-year-olds and those registered blind or partially sighted. However, there are exemptions for students in training and also it is commonplace for a registrant to delegate tasks, such as fields and pressures, to non-qualified colleagues. In these cases the registrant has a responsibility to supervise any regulated activity and both supervisor and supervisee should understand their roles.

Supervision means that the supervisor is on the premises, able to intervene if necessary. Being in a consulting room, while dispensing is happening outside is acceptable, as is being upstairs in the practice office/tea room. In these cases it is known where the supervisor is and they can be called to assist. Not being on the premises, for instance in the shopping centre, is not acceptable.

The supervisor must be aware that they are the responsible person within the practice. This will be particularly relevant if the registrant is new to a practice or visiting for a day, as in the case of a locum. They should be aware of who they are delegating tasks to and whether the supervisee is trained to do the task. This information should be available through the practice training records. The supervisor should make the supervisee aware that they are being supervised and it may be appropriate to check that they are able to perform the delegated tasks through direct observation or questions to test understanding of their knowledge and skills. If the supervisor leaves the premises they should inform colleagues that no tasks requiring supervision should be carried out.

Supervisees should be aware who their supervisor is. They should know the limitations of their own knowledge and skills and that they are able to call on the supervisor for help and support. Both supervisor and supervisee should know those delegated tasks, such as fields or retinal camera, that will require inspection by the registrant before the patient leaves the premises.

In order for supervisors and ▶

colleagues to be aware of their roles and responsibilities, it is advisable to have documentation in practice in the form of standard operating procedures (SOPs). These can be used to set out the practice policy on supervision and other issues within the practice and will be useful to make clear the role each person in the practice has to play and as a training tool for current and new colleagues. They also demonstrate that the practice is taking appropriate governance measures to deliver high standards of care. These should clearly set out the roles of both supervisors and supervisees and can be signed and dated by each person in the practice to indicate they have read and understood them.

Prescriptions

All prescriptions and contact lens specifications should include the name and registration number of the registrant and the practice address of the person signing the specification.

At the end of each eye examination it is the duty of the optometrist to give the patient a written copy of their prescription, stating if optical correction is required and whether the patient is being referred to a registered medical practitioner.

For a contact lens fitting the patient should be given a copy of their specification sufficient to enable the lens to be replicated as soon as the fitting is completed. This is normally when the practitioner is satisfied that lenses give good vision, the patient has adapted to the lenses and ocular health will not be compromised. The College suggests this should be within three months of the initial fitting, and, if longer, this should be noted on the record and the patient advised. The specification will include:

- The patient's name and address
- Date of birth if under 16
- The date the fitting was completed
- Sufficient details of any lens fitted to enable a person who fits or supplies a contact lens to replicate the lens
- The date the specification expires
- Such information of a clinical nature as the person fitting the lens considers to be necessary in the particular case.

The patient must also be given instruction on the care, wearing, treatment, cleaning and maintenance of the contact lens.

Sale of optical appliances

Optical appliances, contact lenses and spectacles, can be sold by an unregistered seller, while the sale to those who are under 16 or registered blind or partially sighted is strictly limited to optical registrants. The College believes that the dispensing of all optical appliances should be carried out under supervision of a registrant. However, the current interpretation appears to be that, even in an optical practice, dispensing to an adult could be carried out without a registrant being on the premises. In this case the patient would have to have a signed written prescription, less than two years old and the prescription must be checked and centration with pupils confirmed. Practices may take their own view as to whether they would like to provide a higher level of care.

All stages of dispensing to a child or registered blind/partially sighted must be supervised. This will include frame and lens selection, measurement of pupillary distance, ordering, checking and the final fitting. This last stage is particularly important and is the final opportunity to confirm that the lenses correspond to the written prescription, that they fit and the visual performance is as intended. It would also be advisable that any future visits to the practice for adjustments, breakages, non-tolerance are supervised.

USEFUL WEBSITES

www.optical.org
www.college-optometrists.org
www.abdo.org.uk
www.aop.org.uk

Summary

Taking the time in practice to consider whether your actions comply with optical regulation will improve patient care and minimise unnecessary worries for practitioners. It is sensible to review potential risks and then take action to minimise the risk and the impact if it does happen. It will be important for all practitioners to keep up to date with current thinking and to adopt their practice accordingly.

David Cartwright is an optometrist working in Nottingham

Professional conduct

Part 3 - Case examples

In the third of three articles, **David Cartwright** looks at recent GOC and civil cases and what we can learn from them to improve our practice

Parts 1 and 2 of this series looked at the legal framework and guidelines against which we practise and some of the actions registrants need to take to comply. To bring these issues to life it is interesting to look at actual GOC fitness to practise committee and civil cases.

Professional conduct

While registrants appear to worry most about their clinical activity, there are a number of examples in recent GOC cases where registrants' actions, not purely their clinical activity, have resulted in suspension, erasure or a warning. It is important that all registrants understand that their professional and private lives are linked. The GOC code of conduct reminds us that our conduct, not only in our professional life but also our personal conduct, can put our registration at risk.

A crime that hit national headlines in 2009 had implications for a registrant who was involved. Individuals were causing accidents and receiving payments from insurance companies, the so called 'cash for crash' scam. An optical registrant was involved on the periphery of this, receiving 200 hours' community service. A FTP committee also found the individual's fitness to practice was impaired by reason of dishonesty and remained concerned that the registrant had not fully faced up to the full nature of what he had done. He was suspended for 12 months.

A GOC case from May 2012 reminds us that registrants have to be aware of their professional position and the relationship with their patients. Also the FTP committee is able to impose an immediate interim order on a registrant where it feels this is necessary for the protection of the public, prior to the case being heard in full. This case was against an optometrist and the patient concerned was a vulnerable teenager. In this circumstance the FTP committee excluded the public from the proceedings in the interests of the maker of the allegation, the patient or witness concerned and the registrant. The hearing was then heard in private and much of the determination is redacted. This means that names and details are removed from the transcript of the case and so it is difficult to know exactly what the case against the optometrist was. However, the committee came to the conclusion that a conditional order was required for the protection of the public due to issues of trust and confidence. This conditional order was for 18 months and in that time the optometrist is required to work under a supervisor, who will monitor conduct and provide reports to the GOC registrar every three months in respect of the registrant's conduct. The optometrist also has to inform any employer, and the local PCT of the conditional registration.

Many of the clinical examples quoted in this article are unusual outcomes from what otherwise were normal interactions with patients

The case reminds us of the need for registrants to be aware of the GOC code of conduct, which states that you should not abuse your professional position. The College guidance also draws attention that 'the optometrist has a duty to do everything possible to promote and preserve patient confidentiality in him/herself and the profession as a whole'.

Other recent examples illustrate that registrants have to be totally honest in both work and private lives.

In one case, dispensing optician registrants working for a company manipulated the sales of certain products in their practice to achieve bonus targets and payments. This gave rise to personal financial gain, but they had acted dishonestly and were reported to the GOC. The FTP committee considered there was a serious breach of trust with one registrant receiving a warning and the other two being suspended.

Another example of dishonest conduct was provided by a case where a registered student falsified a number of letters to her dispensing college purporting to have been written and signed by her employer and confirming that she had started full-time work at a practice. This was not the case and the FTP panel found that this was dishonest conduct which fell short of standards expected by the profession and the public. The sanction imposed was to erase the individual from the register.

With some of these cases it should have been obvious to the registrant that there would be an effect on registration if discovered. However, in some cases it appears that individuals were not really aware of the seriousness of their actions and the consequences. Clearly for each

individual there will be a significant effect on their personal circumstances and any personal gain was far outweighed by the loss in earning capacity, effect on reputation and the ongoing burden of notifying employers and primary care organisations.

Supervision

A 2009 GOC fitness to practise hearing drew attention to the principles of supervision and clarified which parts of the process of dispensing to a patient under the age of 16 required supervision.

In this case a patient under the age of 16 received a pair of spectacles. Some weeks later the patient and parent attended the practice, the patient having noticed that the vision with the spectacles did not seem to be as good as it should be. At this visit, the member of staff who attended to the patient was not a registrant and there was no registered person on the premises. It was noted that the prescription of the spectacles was incorrect and it was agreed to order a new pair to the correct prescription. As it was Christmas Eve the decision was taken to let the child keep the spectacles for use over the Christmas period.

A complaint was made to the GOC by the parent regarding the handling of the supply of the spectacles leading to the child receiving the correct pair. In its investigations the FTP committee decided that the handing back of the spectacles on Christmas Eve constituted a dispensing of the spectacles and was not supervised. It was found that the fitness to practise of the company was impaired and a fine of £30,000 imposed.

The case raised a number of issues, in particular what stages of the dispensing process required supervision in the supply of spectacles to a patient who is under 16 years of age. Key stages to be supervised include: frame/lens selection, PD measurement, placing the order, checking the final spectacles and the fit and collection. The findings of the FTP committee reiterated the meaning of supervision that the supervisor must be on the premises, aware of the procedure taking place and able to intervene to exercise judgment if required. The committee also advised that registrants should be made aware that they have supervisory responsibility.

At the time the GOC chief executive commented: 'Supervision is essential for protecting patients and the public. This case highlights the importance of having proper supervision mechanisms in place, and ensuring those mechanisms are communicated to staff, and implemented at ground level.'

The learning from this case applies to every practice. To confirm common understanding in a practice it would be sensible to have standard operating procedures (SOPs) that set out practice policies with regard to supervision, the role of the supervisor and supervisee and dispensing to under-16s. The SOPs can also cover other issues where it is important to have a common understanding and compliance. SOPs should be signed and dated by all members of the practice team to confirm understanding and will be used when inducting new members of staff and locums. To give further clarity to individual roles and responsibilities, all members of staff should have badges that give name, qualification and role.

GOC registration

Registrants will be aware that as part of the GOC's annual registration process they are required to make declarations of any criminal convictions or cautions.

A case from earlier this year illustrates the importance the GOC attaches to this. The case involved a student dispensing optician who had a series of cautions and convictions from 2007 to 2011. These were for possession of the class C drug cannabis, possession of the class B drug amphetamine, criminal damage of property and driving when over the alcohol limit. However, these had not been declared on applications for registration from 2008 onwards. The registrant had ticked the box to say he had understood the requirements for declarations and did not have any to make.

The FTP panel felt that this was misleading to the GOC and dishonest.

In response the registrant stated on his witness statement that 'I knew I had received a simple caution but, not being a lawyer, I did not think it was a criminal conviction'. Later, in his oral evidence, when it was pointed out that he was required to declare a caution as well as conviction, the registrant claimed that he had merely 'scanned' the question and had not noticed the word 'caution'. In response, as the registrant knew this was an important document, the committee therefore judged it highly unlikely that he merely scanned it as claimed.

The committee considered that the registrant had repeatedly been dishonest by failing to disclose his criminal matters in his applications for retention on the register from 2008 through to 2011. His conduct over this prolonged period was misleading and dishonest and struck at the core of his regulator's function which is to protect the public. Further, the registrant had chosen to dispute that he had been dishonest, had not acknowledged his dishonesty or shown remorse into his dishonest conduct nor had he shown any insight into why this type of dishonesty is of the utmost seriousness.

The committee considered that such dishonest conduct was not easily remediable and had seen no evidence of any attempts by the registrant to remedy it. In conclusion the registrant was erased from the register.

PCT registration

There have been a number of examples in recent years where an individual performer's registration on a PCT's performers list has lapsed, causing issues when he or she continued to work. One example of this was where an optometrist was registered with the PCT in the region he was working but then moved away to work in another PCT region. He was still able to continue to perform NHS eye examinations because an optometrist who is on a PCT's performers list may perform primary ophthalmic services in any PCT in England. However, after a year, the PCT where the optometrist was registered, but no longer working, removed him from the list.

Some six months later it came to light that the optometrist was no longer registered on a performers list and the PCT in which the optometrist was now working requested that all NHS sight fees during the period of non-registration be returned. In this case the contractor bore the cost.

This is an unusual case, but by no means unique. The optometrist should have notified the PCT of his change of address, and this would have meant that he would have received notice of intent to remove him from the list. It would also be sensible for all contractors to confirm yearly that employees and locums have a current PCT performers list number. For optometrists who have a break from practice, for instance a gap year, it would be sensible to make ongoing arrangements to keep registrations in place.

Retinal detachment

The issue that possibly causes most clinical errors is the failure to act appropriately when a patient presents with symptoms that may suggest a retinal detachment. The optometrist often recognises the symptoms may

indicate a serious condition, but does not take steps to vary his or her routine to conduct other investigations to eliminate or confirm this.

One such case before the FTP committee was brought by a member of the public who had attended for an eye examination having noticed a sudden increase in flashes and floaters. The optometrist conducted his normal examination, but did not dilate the patient and did not examine the anterior chamber to establish the presence or otherwise of 'tobacco dust'. There was also no advice given to the patient regarding what to do if he noticed other signs which may indicate a detachment. One day later the patient noticed a loss of vision in one eye and attended casualty where a retinal detachment was diagnosed. The committee found that the optometrist had not acted properly in the eye examination and had not taken note of, or acted upon the information that was presented to him. It was also noted that at this visit and on previous visits the optometrist had not enquired about general health and medication or noted this on the record.

The FTP committee found the optometrist in breach of articles of the GOC's code of conduct:

- Make the care of the patient your first and continuing concern
- Maintain adequate records
- Keep professional knowledge and skills up to date.

The committee found the optometrist guilty of misconduct. However, it did recognise that this was the first time there had been any complaint about the optometrist and the previous good record was supported by references and testimonials. The committee also took into account that the optometrist was open and honest in his admissions and his good level of insight into his failures. He had taken comprehensive steps to remedy his practice. This included extending consultation times, improving record card completion and undertaking regular audit with a colleague. The committee therefore concluded that it was unlikely that these mistakes would be repeated and issued a warning for three years.

This case reminds us of the importance of a number of aspects of good practice. Keeping good records is essential to help guide what we need to do in an examination and also to show where we have undertaken a test to exclude a possible condition. It is also important not to undertake a 'scattergun' approach to tests, but consider which tests are most appropriate to the patient's signs and symptoms.

Valuable lessons can be learnt from retinal detachment cases

It also illustrates the point made in a number of GOC cases that where the registrant acknowledges his failures or the seriousness of his actions and has taken steps to prevent a recurrence, the committee has viewed this positively.

Retinal detachment cases also illustrate examples of good practice, where a patient has attended a practice complaining of the recent onset of floaters. To cite one example, a patient presented at a practice where there was no registrant on the premises. The optical adviser who talked to the patient correctly recognised the potential seriousness of the condition. The patient was advised to attend eye casualty and a detachment was found and treated and the patient was delighted with the advice received. The optical adviser had correctly made a note of the conversation and advice given on the record card and in doing so protected the practice against any claim in future if the patient claimed that no advice had been given or that he had described other symptoms not acted upon. This appears to be a feature of some cases, where the patient later finds that a particular condition is characterised by certain signs and then claims to have described these when it was not actually the case.

Glaucoma

Not surprisingly, glaucoma features in many complaints made against optometrists. A common theme in these complaints is the failure to conduct appropriate tests on patients who are at risk.

A complaint that illustrates this is where a 57-year-old patient attended for an examination and reported a family history of glaucoma. Pressures, (16,18mmHg) and fields were normal and a cup/disc ratio of 0.4 recorded. The next three examinations, one year apart, did not include fields, pressures were again in the high teens and cup/disc ratio recorded as 0.6. No note was made of the family history of glaucoma. The next examination, by the original practitioner, found a considerable field defect, the patient was referred and glaucoma confirmed.

The patient brought a civil case against the practice and an expert witness confirmed that the middle three examinations did not take into account the risk factors for the patient; fields should have been undertaken and the change in cup/disc ratio considered. The case was settled out of court.

Again there are valuable lessons to be learnt from this case. Optometrists must keep up to date with current good practice. They should recognise the risk factors associated with common ocular conditions and know which tests need to be conducted. The College gives clear guidance on dealing with patients with a number of common conditions.

Optometrists should also review previous record cards for each patient. While the results from tests in the current examination may appear normal, it is important to identify if they have changed from previous results, indicating a progressive condition.

A further example of the need to look at old records is illustrated by a patient who presented with a history of a 'lazy left eye'. Visual acuity in this eye was 6/12, seemingly due to an esotropia and all else in the examination was found to be normal. The next two examinations were also found to be normal; however, it was noted that the acuity in the left eye had reduced to 6/36. The assumption was made that this was due to the esotropia and presumably no reference to previous examinations was made.

The patient was subsequently diagnosed with glaucoma, which was the cause of the reducing acuity in the left eye. An expert witness identified that the reducing acuity should have been noted and investigated and the case was settled.

A common factor in both these cases is that the optometrist was not alerted by significantly high pressures, did not consider normal tension glaucoma and so did not investigate further.

Communication

There are many examples of errors of communication that have led to a complaint against an optometrist. Perhaps most common is the failure to inform of the presence of cataracts. It is well documented that a patient ▶

should be informed of the outcome of an examination and this applies even when a condition, such as cataract, is normal for the age of the patient. In the author's experience, telling a patient sympathetically that he has cataract and dealing with any worries they have causes far fewer problems than not telling the patient and the anger that is caused when they found out you knew but did not tell him. This is emphasised in the College guidance; patients have a right to know what is happening in their body and it is advisable to tell the patient that they have some slight cataract, even if this is not bad enough to warrant referral. This avoids the patient being examined elsewhere, being told they have cataract, and therefore assuming that the first optometrist 'missed' it.

The speed of referral is also a significant issue in the communication of your findings to your patient and also to other practitioners. An example is where an optometrist correctly identified a superior field defect, near to the macula, that was thought to be due to detachment. The patient was referred with a request to his GP that 'ophthalmological opinion is required'. The patient lost vision and an expert witness suggested that the optometrist should have considered the degree of urgency and instructed the GP accordingly. This seems a reasonable conclusion as optometrists have the knowledge to decide how serious the condition is and how urgently the patient needs to be seen.

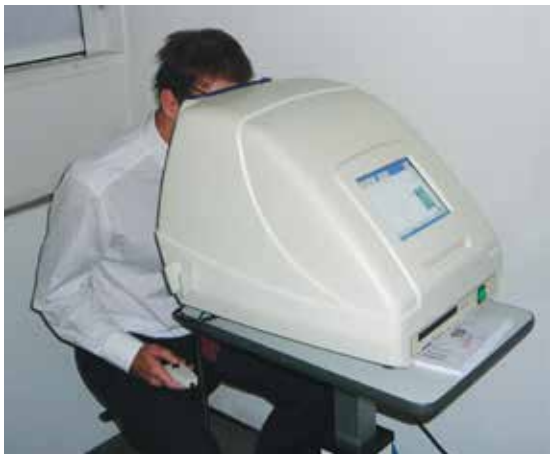
The College gives guidance on conditions requiring emergency and urgent, (one week) referral.

In giving advice to a patient it is also good to confirm this in writing, using material in the practice or one of the many leaflets that are available through suppliers or the College.

Dispensing

Eye examinations may only be undertaken by optometrists and medical practitioners, after which a signed, written prescription should be given. An interesting case involving a new prescription illustrates the responsibilities of dispensing opticians.

A patient received a new prescription, which was slightly weaker for reading than the previous prescription. This was dispensed. However, the patient attended the practice a week after collecting the spectacles complaining that she was not seeing well from one eye when reading. The dispensing optician who attended the patient felt this was due to the prescription being weaker and took it upon themselves to increase the reading addition. However, it transpired the patient was actually noticing the first signs of wet age-related macular degeneration.



Failure to conduct appropriate tests was a common theme in cases involving glaucoma

This example reminds us that the dispensing optician should not have changed the prescription as only the optometrist/medical practitioner is able to do so. Also a registered DO has a duty to refer a patient to an optometrist or a medical practitioner if it appears a patient is or may be suffering from disease or injury of the eye and also should be aware of ocular emergencies that would require direct referral to hospital.

The responsibility of a dispensing optician to recognise the possible signs of ocular disease is also illustrated in the case of a contact lens practitioner who dealt with a patient who had noticed a deterioration in vision. This was a difficult fitting and throughout the patient complained that his vision was not as good as expected. It transpired that the patient was suffering from the early stages of glaucoma. It was agreed that the contact lens practitioner should have considered other reasons for the decrease in vision and damages were paid.

Summary

Many of the clinical examples quoted in this article are unusual outcomes from what otherwise were normal interactions with patients. In comparison to the 20 million plus examinations that are conducted in the UK each year, examples where something goes seriously wrong are rare. However, this is something that practitioners should be aware of and at the end of a patient interaction consider whether they have addressed the presenting signs, symptoms and findings.

● Next month we will be publishing an online exercise related to the articles in this series.

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