Failure to recognise dilated pupil examination indicated
(15HDC01684, 29 November 2016)

Optometrist ~ Dilated pupil examination ~ Retinal detachment ~ Follow-up advice ~ Standard of care ~ Right 4(1)

A woman, aged 55 years, visited an optometrist for a routine eye examination. The woman informed the optometrist that she was having difficulty with her right eye and that it felt as if a hair was irritating it. The optometrist recorded that the woman's eye had felt this way for the past month, and had not changed shape, size or colour.

The optometrist used a light to examine the woman's eye. He said that her vision was clear, and that there was no vitreous dust (pigmented cells in the vitreous) or monocular colour defect (colour vision deficiency in either eye). He also noted the presence of a horizontal solid floater (a spot in a person's vision). Given his clinical findings, the optometrist decided not to dilate the woman's pupil. The optometrist did not provide any follow-up advice, but prescribed the woman a new pair of long-distance glasses.

Five days later, the woman returned to collect her glasses and spoke with the dispensing optician. The woman asked for her records, as she wanted a second opinion. The dispensing optician said she would arrange this with the optometrist. The woman did not see the optometrist that day.

The following day, the woman returned to the optometry clinic wanting a second opinion. As the clinic did not have an optometrist working that day, the dispensing optician contacted another clinic, and the optometrist at that clinic saw the woman immediately. The second optometrist dilated the woman's pupil and diagnosed a retinal detachment. The woman was referred urgently to hospital and underwent surgery two days later.

It was held that, by not recognising that a dilated pupil examination of the woman's right eye was indicated, and by not providing appropriate follow-up advice to the woman in the event that she experienced further deterioration in her right eye, the optometrist failed to provide services to the woman with reasonable care and skill, and breached Right 4(1). It was held that the optometry clinic did not breach the Code.

It was recommended that the optometrist provide the woman with a written apology and that the optometry clinic use the report as a case study for its optometrists.

The Optometrists and Dispensing Opticians Board of New Zealand was asked to consider whether a review of the optometrist's competence was indicated, should he return to practise.