Failure by optometrist to conduct appropriate investigations and institute ongoing treatment plan
16HDC00646, 6 December 2017

Optometrist ~ Optometry practice ~ Amblyopia ~ Exotropia ~ Investigations ~ Referral ~ Treatment plan ~ Documentation ~ Right 4(1)

A six-year-old boy presented to an optometry practice. He was seen by an optometrist who recorded the reason for the boy's presentation as "routine". No details of the boy's symptoms, family ocular history, general health or medications were documented.

The optometrist recorded the boy's visual acuity in the left eye as "6/10", and in the right eye as "6/x" — that is, the boy could not identify letters on the Snellen chart at six meters with his right eye. The optometrist made a diagnosis of amblyopia and possible right eye exotropia, and prescribed the boy with glasses. No plan for follow-up or further investigation was noted. The optometrist did not refer the boy for further testing, or perform appropriate diagnostic tests to rule out pathology.

Approximately 14 months later, the boy presented to his GP with headaches, and increased problems with his vision. He was subsequently diagnosed with a brain tumour.

Findings

The optometrist breached Right 4(1) by failing to take appropriate steps to test the level of acuity of the boy's right eye or consider differential diagnoses before making a definitive diagnosis of amblyopia; failing to conduct further investigations or refer the boy to an ophthalmologist to determine the cause of the amblyopia and queried exotropia; failing to institute an ongoing treatment plan and regularly assess whether the boy's visual acuity was improving; and failing to document appropriately the patient history and reason(s) for the boy's first consultation.

The optometrist was acting as an agent for the optometry practice. Accordingly, the optometry practice was found vicariously liable for the optometrist's breach of Right 4(1). Adverse comment was also made regarding the failure of the practice to have policies or procedures relating to staffing levels when unexpected leave was required, and regarding the standard of the consultation form that was used at the time of these events.

Recommendations

It was recommended that the optometrist apologise for his breach of the Code. The optometrist told HDC that he is no longer practising as an optometrist. It was therefore recommended that the Optometrists and Dispensing Opticians Board consider whether a review of his competence is warranted, should he return to clinical practice.

A number of recommendations were also made to the optometry practice, including education of clinical staff, review of processes and audit of referrals.