

**BEFORE THE FITNESS TO PRACTISE COMMITTEE
OF THE GENERAL OPTICAL COUNCIL**

GENERAL OPTICAL COUNCIL

F(11)02

AND

DAVID THOMAS ROGER AUSTIN (D-3793)

DETERMINATION OF THE INQUIRY: 3-4 OCTOBER 2011

On 3-4 October 2011, the Fitness to Practise Committee of the General Optical Council met to consider allegations against David Thomas Roger Austin.

An application was made by Mr Whalley, on behalf of the Council, to amend particular 5 of the allegation. The application was unopposed by Mr Payne, for the registrant and the Committee agreed to amend the allegation.

ALLEGATION

The Council alleges that in relation to you, Dr David Austin (a registered dispensing optician) that:

1. Between October 1991 and July 2006 you did not refer Patient A for regular sight tests/full eye examinations with an Optometrist or other suitably qualified person.
2. On or around August 2006 you did not ensure the safe keeping of Patient A's client records and as a result the client records have been lost.
3. Between October 1991 and July 2006 you did not provide Patient A with a completed and signed written specification for each lens which was sufficient to enable the lenses to be replicated.
4. Between October 1991 and July 2006 you continued to fit and dispense contact lenses to Patient A in circumstances where you did not have a valid, signed, written spectacle prescription.
5. Between October 1991 and July 2006 you continued to dispense to Patient A precision UV lenses from CIBA Vision knowing that he was wearing them for

up to 3 months, which was contrary to the manufacturer's labeling instructions of one-seven days wear and there was no clinical need for such extended wear.

And by virtue of the matters set out above your fitness to practise is impaired by reason of your:

- (a) Misconduct
- (b) Deficient professional performance

DETERMINATION

Findings in relation to the particulars of the allegation

The registrant admitted particulars 1, 2, 3 and 4 of the allegation and the Committee accordingly found them proved.

Particular 5 was contested.

Findings in relation to the facts

The sole issue that the Committee was asked to consider in relation to particular 5 was whether the Council had proved, on the balance of probabilities, that there had been "no clinical need for extended wear".

The Committee heard evidence from Mr Blake, the expert witness for the Council, and from the registrant in addition to the documentary evidence put before it today. The Committee accepted the advice of the legal adviser.

The Committee concluded that the two reasons put forward by the registrant for continuing to dispense, namely:

- i. A difficulty that Patient A claimed to have with the insertion of his lenses; and
- ii. The preference that Patient A expressed for wearing lenses rather than spectacles when participating in sporting events

did not amount to "a clinical need".

Further, the Committee was concerned that the registrant had allowed this patient to dictate to him rather than maintaining his professional authority.

The Committee found particular 5 of the allegation proved.

Findings in relation to deficient professional performance and/or misconduct

The Committee has heard submissions on behalf of the Council and the Registrant. It has accepted the advice given to it by the Legal Adviser.

This hearing concerned Patient A under the care of Dr Austin, the registrant, a Dispensing/Contact Lens Optician, during the period of October 1991 to July 2006. Patient A attended Julian Gunn Opticians (Norwich) in July 1991 when he had an eye examination. He was then referred to Dr Austin with his prescription for a contact lens fitting. No records of further eye examinations are available to the Committee as the records have been lost as accepted and admitted by Dr Austin.

Patient A was fitted by Dr Austin with Precision UV lenses supplied by CIBA Vision. This is a high water content hydrogel contact lens for which the manufacturer's recommended wearing schedule is daily wear for a duration of one month (to avoid doubt this means removal of the lenses in the evening together with disinfection overnight before reinsertion in the morning). Alternatively the lenses can be used for 1-7 days on an extended wear schedule. In both cases the lenses must be disposed of after the respective periods of wear. The Committee accepted that this was the lens supplied to Patient A in the absence of record cards. The production of a contact lens prescription card (undated) supplied by Dr Austin to Nigel Burnett-Hodd, an Optometrist, on patient transfer, indicated this to be the case. Although the card is undated, the card post dates Patient A's last contact lens after-care appointment with Dr Austin on 21 July 2006.

During the 15 year period between October 1991 and July 2006 Dr Austin admitted that he did not provide Patient A with a completed and signed written specification for each lens which was sufficient to enable the lenses to be replicated.

Patient A transferred with Dr Austin to his new practice at Perfect Vision (Diss) in 1993. Patient A continued to be seen and supplied with Precision UV contact lenses until his contact lens service closed in 2006 to allow Dr Austin to pursue his academic interests.

Despite being aware of the manufacturer's recommendations regarding wearing schedules, Dr Austin reported to the Committee that he was encouraged by Patient A into allowing extended use, for a single wear period of up to 3 months at a time.

The Committee first considered whether there had been deficient professional performance. It had regard to the case of *Calhaem-v-GMC*. In particular the principle that "deficient professional performance" is conceptually separate from negligence and from misconduct. It connotes a standard of professional performance which is unacceptably low and which, save in exceptional circumstances, has been demonstrated by reference to a fair sample of the work.

Mr Payne has accepted that the admissions entered on behalf of the registrant to Particulars 1, 2, 3 and 4, combined with the finding of the Committee in relation to Particular 5, at the fact finding stage, amounts to deficient professional performance. The Committee concurs with that view. The Committee is satisfied that it has been presented with a fair sample of the registrant's work, stretching over 15 years. The Committee finds that over that period of time Dr Austin failed to demonstrate the standard of care and professional performance that would be expected of a reasonably competent dispensing optician. This has been demonstrated by his repeated failure to refer for regular eye examinations, loss of patient records, failure to provide a signed and written specification for the contact lenses supplied, and continuing the supply of contact lenses to Patient A in the absence of a recent signed prescription. Further, he continued to supply Precision UV lenses on a single use 3 month extended wear basis clearly contrary to the manufacturer's recommendations whereas a reasonably competent dispensing optician would have exercised authority to make the care of the patient his first and continuing concern. The Committee accordingly finds that the registrant's acts and omissions amount to deficient professional performance.

The Committee went on to consider misconduct. The Committee noted the case of *Roylance-v-GMC*, and in particular the direction that the conduct complained of must be serious.

The Committee concluded that the failure to refer Patient A for regular sight tests or full eye examinations with an Optometrist or other suitably qualified person was a serious failure in that there was, to the registrant's admitted knowledge, a history of glaucoma within the family. As of 2005 there was also the legal requirement for eye examinations to be up to date before contact lenses could be supplied.

The Committee concluded that the fact that the registrant continued to fit and dispense contact lenses to Patient A for such a long period of time in circumstances where he did not have a valid, signed, written spectacle prescription was a serious breach of Code 1 of the Code of Conduct for Individual Registrants dated 30 June 2005 ("The 2005 Code"). This is the requirement that the registrant makes the care of the patient his first and continuing concern.

The Committee found that the registrant had also breached three competencies, namely:

- Competency 2 "the ability to select the most appropriate contact lens for the planned use and clinical needs of the patient, and to assess the fit of rigid and soft contact lenses";
- Competency 8 "the ability to communicate effectively with the patient and any other appropriate person involved in the care of the patient"; and
- Competency 9 "the ability to comply with professional and legal requirements regarding the care of a contact lens patient."

The Committee concluded that the fact that the registrant continued to dispense to Patient A Precision UV lenses knowing that Patient A was wearing them for up to 3 months, contrary to the manufacturer's labelling instructions of one to seven days wear, where there was no clinical need for such extended wear, for a period of approximately 15 years, was a serious breach of Code 1 of "The 2005 Code". This is the requirement to make the care of the patient his first and continuing concern. It was also a breach of Code 5 of "The 2005 Code", namely the requirement to give patients information in a way they can understand and make them aware of the options available. It was a breach of Competencies 2 and 9, namely the ability to select the most appropriate contact lens for the planned use and clinical needs of the patient, and to assess the fit of rigid and soft contact lenses, and the ability to comply with professional and legal requirements regarding the care of a contact lens patient. Further it was a breach of Competency 2.1 of the General Optical Council Core Competencies for the Speciality of Contact Lens Practice (2004), namely demonstration of the ability to manage a patient's care in a safe, ethical and confidential environment.

Looking at the matter holistically, the Committee concluded that the acts and omissions of the registrant set out in Particulars 1, 4 and 5 amounted to misconduct.

The Committee then went on to consider impairment.

Findings regarding impairment

The Committee has heard submissions on behalf of the Council and the registrant. It has accepted the advice given to it by the Legal Adviser.

The Committee has borne in mind throughout the need to protect the individual patient, and the collective need to maintain confidence in the profession as well as declaring and upholding proper standards of conduct and behaviour, including the protection of

patients and maintenance of public confidence in the profession. The Committee has considered the way in which the registrant has acted in the past, both before and after the matters complained of.

Dr Austin has demonstrated an insight into his actions by reassuring the Committee in his testimony that he would never repeat his actions. He would never allow a patient to dictate to him wearing patterns or indeed any other aspect of his contact lens wear and care regime. He has further illustrated this by designing and implementing training materials which clearly include the need for regular eye examinations and the issue of contact lens specifications as designated by the Opticians Act 1989 (as amended).

The Committee accepted Dr Austin's genuine remorse and apology to both the profession and Patient A via the GOC for actions and omissions over a sustained period of time. Dr Austin presented the Committee with testimonials from academic colleagues which all speak of his diligence and professionalism.

Mr Payne highlighted Dr Austin's long and unblemished record together with the fact that no further incidents have occurred.

Therefore, despite the misconduct and deficient professional performance found, the Committee find that the fitness of David Austin to practise as a dispensing optician is not impaired.

Warning

The serious nature of the incident nevertheless is a matter of concern for the Committee and whilst it has found that Dr Austin's fitness to practise is not impaired, it is particularly concerned at the potential impact that such conduct may have on the confidence of the public in the profession. The Committee is therefore minded to issue a warning to Dr Austin as to his future conduct and for the warning to remain on his record until 3 October 2016.

Chairman of the Committee: Mercy Jeyasingham

Signed _____ Date 4 October 2011

Registrant: David Austin

Signed _____ Date 4 October 2011

FURTHER INFORMATION
<p>Transcript</p> <p>A full transcript of the hearing will be made available via the GOC website in due course.</p>
<p>Appeal</p> <p>Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).</p>
<p>Council for Healthcare Regulatory Excellence</p> <p>This decision will be reported to the Council for Healthcare Regulatory Excellence (CHRE) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. CHRE may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been unduly lenient and/or should not have been made, and if they consider that referral is desirable for the protection of the public. CHRE is required to make its decision within 40 days of the hearing (or 40 days from the last day on which a registrant can appeal against the decision, if applicable) and will send written confirmation of a decision to refer to registrants on the first working day following a hearing. CHRE will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless CHRE has been notified by the GOC of a change of address).</p> <p>Further information about the CHRE can be obtained from its website at www.chre.org.uk or by telephone on 020 7389 8030.</p>
<p>Effect of orders for suspension or erasure</p> <p>To practise or carry on business as an optometrist or dispensing optician, to take or use a description which implies registration or entitlement to undertake any activity which the law restricts to a registered person, may amount to a criminal offence once an entry in the register has been suspended or erased.</p>
<p>Contact</p> <p>If you require any further information, please contact the Council's Hearings Manager at 41 Harley Street, London, W1G 8DJ or, by telephone, on 020 7580 3898.</p>