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

GENERAL OPTICAL COUNCIL

AND

DAVID THOMAS ROGER AUSTIN (D-3793)

Monday, 3 October & Tuesday, 4 October 2011

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SUBSTANTIVE HEARING: DAVID THOMAS ROGER AUSTIN (D-3793)

DAY ONE

Monday, 3 October 2011

FTP Committee: Ms Mercy Jeyasingham MBE (Chair) (Lay)
Dr Dozie Azubike (Lay)
Mr Duncan Counter (Dispensing Optician)
Mr Hilary King (Dispensing Optician)
Mr Rodney Varley (Lay)

Legal Adviser: Ms Lucia Whittle-Martin

Hearings Manager: Mr David Henley BEM

For the GOC: Mr Christopher Whalley

For the Registrant: Mr Richard Payne

[Proceedings commenced at 09:57 hrs]

Chair: Good morning. I am Mercy Jeyasingham, a lay member of the hearings Panel and I have been elected by the Committee to chair today's hearing. The Committee today is made up of two dispensing opticians and three lay members and I will ask the members of the Committee to introduce themselves and the capacity in which they sit. *[Introductions made]*

To my right is Ms Lucia Whittle-Martin, the Committee's Legal Adviser, who will provide legal advice and assistance to the Committee and ensure that the proceedings are conducted in accordance with the Rules of Procedure, so as to arrive at a result which is fair and just. The Legal Adviser may accompany the Committee should it sit in private to deliberate. In the event that any matter arises during the course of the Committee's deliberations upon which the Committee seeks advice, the parties will be invited to return to hear the matter which the Committee has raised and the advice to the Committee. Where advice on any issue is not accepted by the Committee, this will be indicated in the course of its decision on that issue.

To your right is David Henley, the Hearings Manager, who will provide administrative support to the Committee. Next to Mr Henley is the transcriber, who will be keeping an official record of all that is said today during the sessions today of the hearing at which the parties are present. The remaining

persons sitting in the hearing room are members of the respective legal teams.

All parties are reminded that, where details of the patient are to be discussed, that patient should only be referred to as Patient A. Where the patient's name is mentioned during the course of the hearing, the transcriber will delete the name from the transcript and replace with the words 'Patient A' or 'the patient'.

It is the Council's policy for the Determination of the Committee and a transcript of proceedings to be displayed on the Council's web site for public viewing but, where matters of health have been discussed, the Determination and transcript will be redacted accordingly.

It is my understanding that there is an application about the amendment to the allegation?

Mr Whalley: Yes, Madam, that is correct. If I can ask you please to turn to the allegations, which are at page 1 of the Council's bundle?

Ms Jeyasingham: And this is C1.

Mr Whalley: If I can deal with an amendment first of all, to Allegation 5. There has been an element of re-drafting, so perhaps if I can read out what the new allegation should read, please?

"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 three months, which was contrary to the manufacturer's labelling instructions of one to seven days wear and there was no clinical need for such extended wear".

Ms Jeyasingham: I will just check if Mr Henley has that? You might need to repeat, Mr Whalley.

Mr Whalley: Absolutely. [*New drafting of allegation repeated*]

Ms Jeyasingham: Mr Payne, is there a response to that, or is that accepted?

Mr Payne: Yes, that is accepted, thanks.

Mr Whalley: And the other – as I say, it is not an amendment as such, Madam. It is Allegation 1 but there is a basis upon which that allegation is accepted and Dr Austin will set out his position by Mr Payne. So there isn't an amendment to that, but perhaps if that could be made clear when the allegations are put to Dr Austin and that can be explained.

Ms Jeyasingham: Right. Thank you.

Mr Whalley: I do have some additional documents, Madam, if I can perhaps deal with those at this stage?

Ms Jeyasingham: Right.

Mr Whalley: The first document is a copy of the labelling instructions, which are mentioned in Allegation 5 – I apologise, they are not stapled. There are two pages which I showed to Mr Payne. It is a document which Mr Blake, the expert witness, has kindly provided this morning and I apologise for it not being disclosed in advance but I understand Mr Payne has no objection to that being admitted. [*Document C2 distributed*]

Madam, other documents which I have are the *Codes of Conduct* from 2005 and the *Core Competencies* from 2004, because the allegations refer to the period from 1991 to 2006. My instructions from the GOC are that the first published *Competencies* and *Codes* are in fact these ones – 2004/2005. There was nothing before that date so they will be relevant at the stage where you will be considering deficient professional performance and misconduct, should indeed you get to that stage. Perhaps if I can hand these up as well? They are separated. [*Documents C3 and C4 distributed*]

There is the 2005 *Code of Conduct*. Then you have *Competencies for Contact Lens Practice* and they are from November of 2004.

Ms Jeyasingham: So C3 is the 2005 *Code of Conduct*?

Mr Whalley: Yes, Madam. Perhaps if C4 could be the *Competencies*, they can be put together as one document. That is it, Madam, thank you very much.

Ms Jeyasingham: Thank you, Mr Whalley.

In which case, can I ask Dr Austin to stand whilst the Allegations are read out, please?

Mr Henley:

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

1. Between October 1991 and July 2006, you did not refer Patient A for regular sight tests/full 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 complete 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 recommended to Patient A a wearing schedule of up to three months for precision UV lenses from CIBA Vision, which was contrary to the manufacturer's labelling instructions of one to 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.”

Ms Jeyasingham: Thank you. You may sit down. Are any of the facts as set out in the Allegation admitted?

Mr Payne: Yes, Madam. If I can take you through the allegations? As my friend Mr Whalley said, with regard to (1), that is accepted. We understand, of course, that Patient A cannot be here today and there is a factual dispute there. But it is accepted upon the basis that, as per Dr Austin's evidence that he made oral referrals and advised Patient A to see his colleagues for eye tests but has also accepted, upon the evidence, that that did not happen. Dr Austin accepts that what Mr Blake sets out in his expert's report would have been the correct practice to ensure that there is a written referral and so forth, so it is accepted that, if I can put it this way, there was no effective referral – effective in the sense that Patient A did not see an optometrist to have his eyes tested. So as indicated, upon Dr Austin's evidence – and in his statement he says that he made verbal referrals – it is accepted that there was no effective referral and there was no written referral. The Allegation is admitted on that basis.

Madam moving to (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;”

- that is admitted.

Allegation (3),

“Between October 1991 and July 2006, you did not provide Patient A with a complete and signed written specification for each lens which was sufficient to enable the lenses to be replicated;”

- that is admitted.

Number (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;”

- that is admitted.

With regard to (5), my friend has indicated the amended wording. If I can put it this way, this is partially admitted. The amended wording,

“Between October 1991 you continued to dispense to Patient A precision UV lenses from CIBA Vision, knowing that he was wearing them for up to three months, which was contrary to the manufacturer’s labelling instructions of one to seven days’ wear”,

- that part of the allegation is admitted and Dr Austin admits that the labelling instructions were ‘one to seven days’ wear’. He admits continuing to dispense the lenses over the period alleged knowing that Patient A was wearing for sometimes up to three months – one or two months. So that side of it is admitted. But the second part of that allegation – “there was no clinical need for such extended wear” – that is in dispute and that is denied because Dr Austin will say in his evidence that the matter had been carefully considered and there were reasons for the continuing use and prescription of those lenses and fitting of those lenses.

So, this is, Madam, the position on (5). In terms of (6), it is denied that by virtue of matters set out his fitness to practise is impaired by reason of deficient professional performance and or misconduct, and Dr Austin will submit in due course that his fitness to practise is not impaired by the allegations that have been admitted.

Madam, it would appear – and following discussions with my friend – that the item in dispute at this stage is this element, the second element of allegation (5) about the clinical need for such extended wear, and there does not appear to be a dispute upon the facts now.

Ms Jeyasingham: Thank you, Mr Payne. Mr Whalley?

Mr Whalley: Madam, I can now very briefly open the case before calling the first and only witness for the GOC, Kevin Blake, given the very helpful admissions from Dr Austin. The evidence of Patient A is not in dispute, save for that one point which has been dealt with in Allegation (1). As such, the only issue really to deal with is Allegation (5) and Mr Blake's evidence and his opinion on that particular matter.

Before I turn to the facts very briefly, Madam, I remind you of course that it is the Council that bring the case and the burden of proof is on them to prove the case. The standard of proof is a civil standard, which is the balance of probabilities. You will no doubt be aware of your decision-making process today but you should, first, consider the facts and at this stage that is all you are considering – whether the facts of the allegation are proven. Of course, given the admissions, you are left with Allegation (5) which is a fact which is still in dispute. You will then go on to consider if any of those admitted facts or indeed any proven facts amount to either misconduct and/or deficient professional performance and finally whether Dr Austin's fitness to practise is presently impaired.

A very brief background: the allegations relate to the treatment provided to Patient A by Dr Austin between 1991 and 2006. Patient A was first referred to Dr Austin following an eye examination in July of 1991. He was then referred to Dr Austin to fit him with contact lenses. That appointment took place in October 1991. Dr Austin prescribed the lenses and Patient A continued to visit Dr Austin for contact lens check ups, as far as he was aware, up until July 2006 – so a considerable period of time: 15 years of treatment from Dr Austin. After that time, Patient A was transferred to Nigel Burnett-Hodd and you will find his witness statements in the bundle. He will not be giving evidence; his evidence is not disputed. He really deals with what happened after the events.

Turning to Allegation (5), my friend has very helpfully set out what the issue is and that is really to do with clinical need. The Council's case – and indeed Mr Blake's evidence – is that once Dr Austin was aware that Patient A was continuing to wear these lenses for three months, which of course at the three month checks he would have been aware of that, he had a duty of care to stop dispensing or give very firm advice that they should not be worn for that length of time. Given the label instructions, which you now have from 2003 but my understanding is that it was the same instructions before that time, it very clearly says they should be worn for one to seven days maximum and certainly not for a three month period. Mr Blake's evidence is that that is not the appropriate advice and Dr Austin also had a duty of care to cease dispensing those if he became aware that they were being worn for that length of time.

I do have further comments to make by way of opening, in terms of deficient professional performance and misconduct and also impairment but I will leave

those comments until we get to that stage. That is all I wish to say about the facts. If I can then, please, call Kevin Blake?

**KEVIN BLAKE, called and sworn
Examination-in-Chief by MR WHALLEY**

- Q.** Mr Blake, good morning. I will be asking you some questions, first of all on behalf of the Council. There may very well be some questions from my left and also from the Committee. Before I turn to the specific issues that the Committee are considering, can you please just explain, firstly, what your qualifications are?
- A.** Okay. I am a contact lens optician. I first qualified as a dispensing optician back in 1991, underwent my contact lens course and then qualified as a contact lens optician in 1998 and then further did my Honours course in 1999 and qualified in 2001 with Honours in Contact Lens Practice. I have worked in a very busy hospital department with a very reputed team of clinicians for about two or three years. I have lectured at university for two years at Aston in relation to clinical contact lens aspects, with Professor Wolffsohn and Dr Shehzad Naroo, and combined that with private practice with Boots Opticians in two different practices. I am also a trainee dispensing optician supervisor and a trainee contact lens optician supervisor and also a contact lens ABDO practical examiner.
- Q.** There have been a number of admissions in relations to these allegations, so your report covers a number of points, which I will not be asking you about. I will obviously be concentrating on what is left in dispute. If I can first ask you to have a look at large bundle in front of you, please, and turn to page 9? Is that a copy of the report you prepared for the purposes of these proceedings?
- A.** That is correct, yes.
- Q.** And that report runs through to page 29 – is that right?
- A.** Yes, it does, sir.
- Q.** And then there are a number of appendices which you provided with that report?
- A.** That is correct.
- Q.** Mr Blake, can I first ask you to set out what the procedure is for a patient visiting a contact lens practitioner, in terms of having regular eye tests?
- A.** Regular eye examinations?
- Q.** What is the procedure – as a contact lens optician – what is the procedure that you adopt?
- A.** Okay. The kind of procedure we would do is when a contact lens patient comes into the practice, we would generally ask him history and symptoms, questioning how the contact lenses are, whether they are comfortable, any aspects of whether the contact lenses are uncomfortable, how is the vision,

any aspects or environments of when the contact lens vision degrades, either towards the end of the day or towards the end of the month of wearing the contact lenses; it depends on what the licensed wearing time of the contact lenses are.

We go through any lifestyle changes of the patient, to make sure that nothing has changed between the last visit and this visit – ie: any hobbies, sports, medications, allergies, general health – family eye history, because family eye history can have a dictating effect on eye conditions that the contact lens optician would not be aware of and may prompt the contact lens optician to give the patient an informed choice that they need to have an eye examination because of such and such. There might be risk to the patient's eye that a contact lens optician would not be qualified to see.

Then they would look at the last time that an eye examination was performed, because it should be written on the records as to when the last eye examination was and if it is not within the general timeframe, as recommended by the optometrist, or more than two years, then we are advised to say that you need to have an eye examination and give that patient the informed choice as to why that eye examination is different from the contact lens check –

- Q.** Sorry to stop you there. And how often should a patient have an eye examination? You referred to two years –
- A.** The maximum is generally two years but it would be on recommendation of what the optometrist has said. So sometimes it might be yearly, so for in the case of somebody who might be at risk of glaucoma or there is glaucoma in the family – for example, like there was with Patient A – then the optician would probably pick up on that and then recommend the eye examination might be yearly instead of the two yearly contact.
- Q.** And what is the procedure for a contact lens dispenser to make that referral for the eye test? How in practice does that work?
- A.** What we would generally do is after we have checked over the eyes and make sure there is nothing clinically significant with the eyes, in the summing up of the actions and recommendations at the end of the appointment, we would go over the findings and explain about the eye examination, what the different findings of the eye examination would be and why it is important to have the eye examination. Some people – a lot of patients – are under the assumption that the checks that we do look at the back of the eye and the front of the eye as a contact lens optician, but the difference in assessments and investigations from a contact lens optician point of view and an optometrist point of view are poles apart. So we concern ourselves mainly with the cornea and the surrounding areas as such of the anterior eye. An optometrist is much more highly qualified and obviously can assess the posterior part of the eye and other aspects concerning different diseases that can happen to the eye.

We give the patient an informed choice as to why they need an eye examination. We would not just say that an eye examination is needed. The other thing is, with the patient journey from an eye examination and the contact lens aftercare, from a patient point of view the journey can look the same. So the patient comes in for a contact lens check, they are asked history and symptoms questions, the eyes are checked using numbers or letters or symbols and then an over refraction is done and then an assessment of the eye is done with a very bright light – okay? On a microscope – and the fact that we call it a microscope might lead the patient to think, ‘Well, if it’s a microscope, they must be looking very in depth at my eye’. But in fact, we are only looking at the front part. Then you get the appliance out, have a look at the general eyes, do your actions and recommendations.

If you look at it from the optometry point of view, from the patient journey, it is very similar. The patient comes in and they are asked history and symptoms questions, they are asked about the vision and the spectacles. The vision is assessed and over-refracted or refracted. Then they take the spectacles off or the prescription is taken out and then their eyes are looked at, with again from a patient’s perspective a very bright light. But the optometrist is looking at the back of the eye and things concerned with the back of the eye and the middle of the eye.

Q. Again, sorry to interrupt you there, but as you said, the end of the appointment comes with the patient, you have that discussion and you advise them to have an eye examination.

A. Yes, we do.

Q. How is that enforced? How can you as a contact lens practitioner ensure that that eye examination actually takes place?

A. What we normally do is we would either take them outside and hand them over to a support staff member to say that Patient X is overdue for an eye examination, ‘Could you please make arrangements to book the patient in for an eye examination?’ or we might say to the patient, if they prefer to go to another optometrist that if they could bring in their eye examination prescription so they have fulfilled the needs for the eye exam to have taken place. What we might do sometimes is we might hold back the supply of contact lenses or maybe give them enough lenses to suffice for a reasonable time course to have the eye examination done, and then supply the rest of the lenses when they have had the eye examination done.

The other aspect with the risk factors, as I said, with Patient A’s mother having potential glaucoma, then Patient A could have had a free eye examination anyway and because he was a hypermetropic patient, because he was over 60, because there was a family history, then that would have all been brought forward to Patient A or a contact lens patient that an eye examination was in order because of the risks.

Ms Jeyasingham: Can I remind you to talk about the patient as Patient A instead of mentioning his name? It will be redacted from the record but – during your evidence?

A. I am sorry.

Mr Whalley: It is probably my fault. I should have told you that.

A. It's okay.

Q. If I can then move on to a different point, if I may, Mr Blake? The lenses which were prescribed by Dr Austin were the precision UV lenses?

A. That is correct.

Q. We have a document which you kindly provided this morning and which I have labelled 'instructions'.

A. That is correct.

Q. In terms of these lenses for particularly the lay members of the Committee, can you explain the type of lenses they are and in what circumstances they are prescribed?

A. Yes. With precision UV lenses they are what we call an old hydrogel material lens, that have a water content to them. So with these ones here, they were what is called a 74 per cent water content lens, 26 per cent of the lens was material. It was a UV protective lens. It was non-ionic, which meant that it was fairly deposit resistant in relation to protein and things. The fact that it was a high water content lens could lead it to spoil and age a lot faster. The lens was okay for extended wear use, for up to one to six days, then it had to be removed and then replaced with a fresh lens.

Q. And we can see, if you would have a look at the document in front of you, which is C2, at the top left section which actually is highlighted, which is:

“Wearing time prescribed by the eye care professional is for extended wear for 1 to 7 days/6 nights of continuous wear”.

Would there be a way for the contact lens practitioner – in this case, Dr Austin – to monitor the length of time that Patient A was wearing these lenses for? Because of course, you provide the lenses, they leave. In this case Patient A came back every three months for a check up but is there a way that you would monitor how long those lenses are being worn for?

A. As contact lens opticians, we generally go by the manufacturers' licensed wearing instructions, because those lenses have been fully tested and researched as to their safe life on the lens. The one thing with the cornea is that it is the most sensitive, most easily damaged tissue of the entire body so if it becomes damaged, the potential for sight threatening pathologies is huge. So the effectiveness of the lens would have been tested by CIBA Vision and there have been numerous guidelines from ABDO and different articles that state that you should not dispense a lens for a wearing schedule outside of what the licensed manufacturers' schedules state.

With the actual lenses, I guess the nature of the prescription from Patient A is that it would greatly put the eyes at risk because first, it is an old hydrogel lens of many different pathologies. The other thing is that around that time, in 1999, there was newer materials coming out called silicon hydrogel materials, that you could wear on a continuous wear basis and the maximum wear time for those was a month. So if they were incredibly much more healthy than what Patient A was wearing, then you would not generally go for a wearing schedule with Patient A on a much more inferior lens for two or three times longer than what a much healthier lens would be – if that is okay to understand!

Q. And in this case, having looked at the documents when you prepared your reports, were there any exceptional circumstances, a reason why in this particular case three months' wear was an appropriate and indeed acceptable length of time?

A. I can see – sometimes in the hospital environments that I used to work in, there might be times for a hospital need to wear a lens maybe outside of the recommended timeframe. But in private practice and in this case here, there was no clinical need to extend the life of the lenses outside of the manufacturers' licensed wearing time. It was only by choice that Patient A, I feel, wanted to wear contact lenses on an extended wear basis. The other thing that should have been done was that there should have been an informed choice to the patient at the time of feeling that he wanted to wear continuous wear lenses as to the risks involved and then let the patient make an informed choice as to whether they actually wanted to carry on. Because a patient may have thought that the continuous wear of lenses may have been an easier, more convenient option for them but when they weigh up the risks involved and the potential sight threatening pathology caused by the nature of their prescription, their mind may have changed.

Q. Thank you, Mr Blake. I have no further questions at this stage. There may well be some from my left and also the Committee.

Cross-examined by MR PAYNE

Q. Thank you, Mr Blake. Can I ask you to turn to Section B in the bundle in front of you - R1, in the last section of that bundle? I am looking at the statement of Dr Austin, which is at 1 to 56 in R1. Have you found the statement of Dr Austin at pages 1 to 56?

A. That is correct, sir, yes.

Q. If I can take you to page 7 of that statement, please? Do you have that, Mr Blake?

A. I do, yes.

Q. Have you seen this statement?

- A.** I have not seen any of this, sir.
- Q.** Okay. It is really on this question of long lens wear, from paragraph 32 onwards. Dr Austin will of course give evidence in due course and the panel have seen this statement. Dr Austin makes a number of points here that I wish to put to you. The first thing is, Dr Austin at paragraph 32 points out that he only had two extended wear patients out of 350 or so on his books at the time we are talking about. You would accept that, presumably? And to that extent you would accept that, for Dr Austin that was very much the exception rather than the rule in his practice with two out of 350?
- A.** Yes, okay.
- Q.** Dr Austin also says, as you can see at paragraph 32, that he does take extended wear very seriously and would only recommend its use in particular circumstances. He also says he gives reasons in that paragraph – I appreciate you may not have seen this before, Mr Blake – but he suggests that refractive surgery and any other corneal remodelling methodologies, orthokeratology, would not have worked effectively or safely but for the prescription range of this particular patient – I will read on (this is paragraph 32). He says:
- “The majority of refractive surgery or orthokeratology are geared towards patients who are short sighted. Patients, such as Patient A, who were long sighted, had limited alternatives. As a result it was considered that extended wear lenses were appropriate for Patient A, who was adamant that he did not want to wear glasses.”
- You would accept that sort of analysis, would you?
- A.** Yes. That is fine. The patient can still wear the lenses full time without wearing spectacles and take them out of a night time.
- Q.** And he goes on to say, at paragraph 33, that patients with high oxygen requirement quickly show adverse effects and find long period of wear difficult. This was not the case for Patient A, that there were not adverse effects that were reported by him. You would accept that as well, presumably?
- A.** There is one important point that would come out there, which is that when he saw Patient A, in order to make sure there was no adverse effect, he would have to see Patient A at the first appointment in the morning, because the lenses were nowhere near the requirement for overnight wear, as far as oxygen transmission through the lens. With the patient being a +7 prescription, that central part of the cornea and the oxygen requirement would have been under compromise and the natural barrier function and the protective functions of the cornea would have been under constant risk. So the only time you could be the most accurate is to see the patient the first appointment of the day.

- Q.** Dr Austin's evidence throughout the lengthy period that he saw Patient A was that at the aftercare appointments at which he saw him he did not display any clinical gradings, as Dr Austin puts it, at paragraph 33, which would have required the cessation of wearing his contact lenses. In other words, he did not see any adverse consequences throughout the period that he was wearing them, in plain terms. Would you accept that?
- A.** On one of the notes that was sent to Mr Nigel Burnett-Hodd, the patient had corneal desiccation, which is physical damage to the cornea caused by dryness and he had vascularisation and the vascularisation is one of the silent no-nos that as practitioners we do not like to see because there are no symptoms for the patient, yet it can be very sight threatening from a peripheral cornea point of view and it indicates that the cornea is under constant threat of lack of oxygen or hypoxia.
- Q.** You are talking about the notes to Mr Burnett-Hodd, I think, at a later time. But throughout the period that Dr Austin was treating Patient A the sort of symptoms you describe and the symptomatology, it was not reported. That is correct, isn't it? Dr Austin says as well –

Dr Azubike: I am sorry, what were the answers to the question?

- A.** If you are going through the time for 15 years and it was recorded except for the note that was handed over, we don't have the records, sir, so we don't know what level of vascularisation that the patient had. It actually went through the neovascularisation stage to vascularisation. So it had progressed.

Mr Payne: In terms of your report, Mr Blake, you have indicated – sorry, I may take some time to find the right page reference. I think it is page 20 of the GOC's bundle. I think you are commenting upon what was observed at Patient A's last visit, Mr Blake, to see Dr Austin. It would be the case, would it not, that the staining observed there in July 2006 was of a low grade as Dr Austin says at paragraph 33 of his statement, and that they were often observed in non-lens wearers, when undertaking long periods of VDU activity. Do you agree with that?

- A.** Yes, I do, sir. It could be seen in non lens wearers but with sleeping in the lenses, it will increase the risk.

Q. Dr Austin says that those signs there at that stage were sub clinical with regard to symptoms.

A. I am very sorry, sir –

Q. I am reading Dr Austin's statement, at paragraph 33. I will read the paragraph for you then I would like you to comment:

“The staining observed at his last visit, in July 2006, was low grade (approx. 0.5) and was of a level often observed in non lens wearers when undertaking long periods of VDU activity. This is what we often

saw in the many office workers attending initial and subsequent visits and is often sub-clinical with regard to symptoms.”

- Do you agree with that statement of Dr Austin?
- A. I might be on the wrong page, I am afraid. I am on the wrong page.
- Q. It is page 7 of the bundle.
- A. I have only got one good ear, sir. I am struggling with my hearing aid because I have got an ear infection. So I can make you out but if you can possibly talk a bit louder, I would be very grateful.
- Q. I apologise.
- A. It is okay. I am sorry.
- Q. I am flitting between your statement and Dr Austin's.

Mr Counter: Back section, the very bottom paragraph – 33.

- A. Okay. If it was approximately 0.5, then one of the things I put in my report was that there was no grading stipulation which would have made it easier for fellow clinicians to follow on, to see whether the staining or the desiccation was clinically significant. If that had been put into the notes of Mr Nigel Burnett-Hodd, then yes, I would agree that would be clinically insignificant. But it was not put in.

Mr Payne: Do you accept as well that Mr Burnett-Hodd did not initially find any lens wear complications and he continued with the same lens supplying to Patient A?

- A. Yes.
- Q. Again, can I ask you if you have Dr Austin's statement at the back of the bundle, or part of the Registrant's bundle? Looking at page 8 of that, it is paragraph 34?
- A. Yes, sir.
- Q. Again, I appreciate, Mr Blake that you have not seen this before and in fairness, you may want to read that paragraph through perhaps, before I ask you the question. I will give you a minute to do that. *[Pause]*
- A. Okay. Reading that, sir, I would be interested in knowing what prescription range would have been used for the study.
- Q. I am just inviting you to read that and I invite the Committee to consider it in due course. As Dr Austin sets out there – he says at the outset – the lens selection is far from straightforward and each person is an individual and has different reactions and so forth.
- A. That's correct. They do.
- Q. But there are different views as to usage of lens and different types of lens and side effects.

- A. That is correct, sir.
- Q. And in fact, Dr Austin goes on at the subsequent paragraph and over the page to consider the silicon hydrogel lenses. You mentioned those earlier on, Mr Blake.
- A. That is correct, yes.
- Q. Then over the page, Dr Austin, referring to some of the letters from Mr Burnett-Hodd and his record, says that Patient A did not get on with the silicon hydrogels and in fact went back to precision UV lenses. That is the case, in this particular instance, isn't it?
- A. Okay.
- Q. It is fair to say as well that obviously your report was compiled from looking at documentation.
- A. That is correct.
- Q. Yes. You had not had the opportunity of discussing matters with Patient A. Is that correct, you have not met Patient A?
- A. I have never met Patient A, no.
- Q. Your report is purely on the papers.
- A. It is just on the notes that I have been provided with, that is correct.
- Q. It is Dr Austin's case that this – in fact you can see from his statement, that he would recommend daily lens removal when possible and appropriate -
- A. Okay.
- Q. But in fact, Patient A was a very forceful individual who made it clear that he did not want that.
- A. Okay, yes.
- Q. How do you recommend dealing with people in that situation, where Dr Austin says the information has been given to a patient and, for reasons of their own lifestyle choice and so forth they choose to ignore those recommendations?
- A. You do get the odd patient who – contact lens patients are a different breed of human being altogether – but you do get patients who might challenge your advice. But from a clinical point of view, you need to make sure that the patient understands the risks of their decision on their eyes. And once you have put across the risk to their eyes, then you would note it on the records that, 'I have advised patient's options and risks with contact lens wear', and then put the ball in the patient's court. The other thing is the patient will be given a patient instruction leaflet and advice and guidelines with their contact lenses. So it is important to instruct the patient to read those in their own time, so that maybe they can understand in their own relaxing time any adverse effects that may cause worry to them and then get back to the practitioner, in which case there are various concerns on the licensing packaging that may, like I said, have worried Patient A.

- Q.** And you, of course, produced very helpfully the manufacturer's instructions -
- A.** As long as it is noted on the records, sir, and the patient knows the risks that is fine. The patient can carry on, I guess, as long as it is on the records.
- Q.** Okay. Thank you very much, Mr Blake. I don't have any other questions but members of the Committee may well.

Ms Jeyasingham: Mr Whalley, any further questions?

Mr Whalley: No, thank you.

Ms Jeyasingham: I will turn to the Committee?

Questioned by the Committee

Mr King: I have a couple of clarification points, please? You qualified in 2001, you stated earlier?

A. From my Honours certification –

Q. As far as the contact lens side of things is concerned? Can I ask you, have you had any personal clinical experience of the precision UV lens?

A. I had a lot of personal clinical experience as daily wear. I would never let the lens be slept in but certainly, with daily wear, with the company that I worked for at that time, it was our monthly replacement lens – one of our monthly replacement lenses at that time – and yes, we did an awful lot of them as daily wear only. But, as stated earlier, they can spoil quite rapidly and are open to contamination effects.

Q. Okay. But never on the extended wear basis?

A. Absolutely never on extended wear, sir.

Q. The other thing I would like clarification on, please, is: when you say you would ensure the patient understands the risks -

A. That is correct.

Q. Can you just define what, in your view, the risks are?

A. Okay. I also need to put it in layman's terms, so the patient understands things as well. So the biggest risk that you can have – well, there are numerous risks with precision UV lenses or hydrogel lenses for extended wear outside the licensed wearing time – is you can get situations like contact lens associated red eye, which is an alarming sort of thing to have but not overly serious. You have giant papillary conjunctivitis, caused by allergic responses on the lens. You have neovascularisation or vascularisation, which is a sight-threatening pathology over a period of time, which is a very real threat with hydrogel lens. And you also have the ever-present risk of microbial keratitis, which is a devastating sight-threatening pathology. It even states in the licensing here that

“the patient is at risk of all sorts of keratitis and it has been shown to be greater among users of extended wear lenses than among users of daily wear. The risk among extended wear lens users increases with the number of consecutive days the lenses are worn”.

Q. So if a patient were to suffer any of the risks that you have laid out, would you expect them then to return to the practitioner on a three-monthly cycle or before, to explain that they were actually getting some sort of disorder?

A. Well, if they were having signs or symptoms, depending on the severity of the signs or symptoms, they would either call the practice if it is during day time hours and if we could fit them in we would certainly fit them in, or depending on the question involved, we might just send them straight to the eye hospital or to a doctor.

Q. So you would expect them to return?

A. Yes. Anything abnormal and certainly if Patient A was wearing contact lenses for a long period of time, they would have known what abnormal would have been.

Q. And that would be outside the replacement cycle?

A. Yes. There is certainly a tremendous amount more risk outside of the licensed replacement cycle.

Q. Thank you. Many thanks.

Dr Azubike: Just a couple of points, really for clarification. If you go to page 7, paragraph 32 of R1, that Mr Payne referred you to –

A. Is that where it states, “I have taken extended wear very seriously”?

Q. Yes, it is. I think Mr Payne asked you whether you accepted that only two of 350 patients of Dr Austin fell under that category. I was not quite sure on what basis did you accept there were only two adults out of 350 patients?

A. I am very sorry, sir.

Q. Mr Payne put the question to you in cross-examination, saying, ‘Do you accept that only two out of 350 patients of Dr Austin were extended wear?’ and you accepted that.

A. Extended wear.

Q. On what basis did you accept that?

A. I accepted it, that two out of the 350 patients were extended wear. I don't agree that I would do it.

Ms Jeyasingham: It is not quite what you asked.

Dr Azubike: Yes, it's not quite.

Ms Jeyasingham: I think the question really is about, apart from that statement being there, have you any other evidence? I mean, why do you accept that statement?

A. I accept that statement. I have never seen this document before, so I accept that statement because it is just written here that Dr Austin fitted two out of 350 patients. So there would be –

Q. But you have not seen any other documentation or any other evidence to actually support that?

A. No, I haven't.

Q. So does that clarify - ?

Dr Azubike: Yes, I think that is fine. I think my last point is just one thing I wanted to be clear about. You said that for extended wear, you would prefer the appointment to be the first appointment in the morning.

A. Yes.

Q. Is that correct?

A. They have to be, sir.

Q. They have to be? So what happens if the appointments are not first thing in the morning? Let's say they are later in the afternoon, is there anything you can add on that?

A. With the patient's prescription and for the lay people on the panel: with contact lenses and the time course that this takes over, contact lenses, the material, had a DKT. So the amount of oxygen that went from the front surface to the back surface was called the DKT and there was research done by Holden and Merck who have put the criteria for not causing any swelling of the cornea during daily wear should be 24 DKT. The precision UV lenses that Patient A wears in a -3 prescription is 27 DKT. Now, -3 prescription is thinner in the centre of the lens. Patient A's prescription in the one eye was a +7. That would be considerably thicker in the centre of the lens, so you would have less oxygen going through the lens, reaching the other side to the cornea. And for the lenses that are being slept in, over a period of time, the lenses would spoil and degrade and the oxygen transmission would be less. So the thicker the lens, the less the DKT would be. With sleeping in the lenses, the DKT for only 4 per cent oedema when the patient wakes up in the morning – or 4 per cent on the cornea – would need to be 87 DKT. So already, the lens does not support the oxygen requirement for sleeping in. So the lens, theoretically, would have caused swelling changes of the corner overnight and at the time of waking. One of the other reasons for that would be the salt concentration of the tears during closed eye conditions would have drawn fluid into the cornea, which would thicken the cornea, and that is outside of wearing the contact lens, so it would have been exacerbated because of the lack of oxygen effects as well, because the contact lens would act as a barrier.

The other thing as well: there was a second criteria put forward by Nathan Efron that said, 'If we can induce an 8 per cent swelling of the cornea, then that swelling of the cornea would dissipate as the day goes on'. But the requirement for that was that the contact lens thickness would have to have been 0.117mm. Now, Patient A's lens in his one eye would have been at least 0.3 to 0.35, so that would have been three times the requirement. So Patient A would have had potentially clinically significant oedema at the time of waking and some of that oedema, as we have just said, can dissipate throughout the wearing time. So you might get striae or folds or hazing of the vision and that would get better as the day goes by. But on the chronic perspective, with wearing the lenses for two or three months outside of the week that they should have been worn in as continuous wear, that would exacerbate the problem and greatly compromise the metabolism of the cornea, the defence and barrier mechanisms of the cornea and put the patient even more at risk.

All right; I hope that clarifies that?

Q. Thank you for that very extensive answer.

Ms Whittle-Martin: No, I have no questions, thank you.

Ms Jeyasingham: In which case, you can step down.

[The witness stood down]

Ms Jeyasingham: Mr Whalley?

Mr Whalley: Madam that is the Council's evidence on the facts stage. I think I should hand you over to Mr Austin.

Mr Payne: Yes, Madam. After discussion with your learned Legal Adviser earlier, I intend to call Mr Austin at this stage to deal purely with the points as to the long wear lenses. So if I could call Dr Austin?

**DR DAVID THOMAS ROGER AUSTIN, called and affirmed
Examination-in-Chief by MR PAYNE**

Q. Dr Austin, first if I could take you, please, to R1, the bundle in front of you, the Registrant's bundle 1? Page 1 to 16 contains your statement and hopefully, on page 16, there is your signature. It is an unsigned copy. I have a signed statement. I do apologise. I thought my colleague had forwarded that to you. Perhaps that could be added, Ma'am, later on.

Dr Austin, if you could confirm however that that is your statement in the bundle and the contents of it are true and you adopt it?

A. As far as I am aware, yes.

Q. Can I ask you briefly – it is in the statement, but for the benefit of the Committee – to outline your experience and then your current position, please, before you start to give your evidence?

A. I studied, as the statement says, through from 1979 to 1981 at City and Islington College and then proceeded through a number of posts, getting registered etc., as the statement says. Purely for academic and because I married my wife, we decided to go to the University of East Anglia and I studied Applied Physics and my wife studied at UEA at the same time. I then carried on with an MPhil and also carried on practice in various posts, right through to 2006.

Q. And your current position, please, Dr Austin?

A. Yes. From 1999 till date I am a Senior Lecturer at Anglia Ruskin University.

Q. I understand you also undertake research work?

A. Yes. I am joint head of a research team with regard to anterior segment of the eye. Peter Allen is my joint group leader and he deals with other aspects of the eye.

Q. Thank you. I am going to ask you about this particular point that you have heard us discussing and again, I have to remind myself and also remind you if possible please to refer to 'Patient A' for the purposes of the transcription. Perhaps you could – it is in the statement but briefly – reiterate to the Committee the initial instructions that you received from Patient A when you first saw him in 1991?

A. I would like just to make it plain, first of all that I am very disappointed that the records have gone astray and that we have a paper trail that is not present. I did see to the best of my knowledge Patient A in October of that year. I again cannot remember whether I was the original prescriber or fitter of those lenses but I remember having quite extensive discussion about extended wear lenses. He was extremely sure that that is what he wanted. We went through again, at the time there were booklets and other pieces of literature which supported a verbal discussion. I certainly wanted him to take them out every night. As you can see, I really do not like extended wear. If people can

remove them I think it is preferable. And he, on a number of trials said that he could remove them but putting in was making it very complicated and he found that actually he was taking multiple attempts, which made it very difficult for him to get lenses in. So he could remove them but couldn't get them in.

Q. Sorry to interrupt you, Dr Austin. Could I take you back – you have given the Committee a lot of information – you have indicated that you discussed the manufacturers' advice and so forth with Patient A. We earlier had put in exhibit C2, which was the advice to accompany the lens, and you accept that that is the advice that accompanies them?

A. Absolutely, yes. That is written, yes.

Q. You said that was given to him. Can I ask you to explain, please, to the Committee what your practice was and what happened with Patient A, with regard to these manufacturers' instructions?

A. First of all, I saw Patient A either at the beginning of the day or during the day and reiterated at each appointment how fortunate he was – he had a very individual situation – that he could wear lenses for longer periods than many certainly could do. However, there were not any clinical issues but I did make him aware, at the discussion at each appointment that this was working for him as an individual.

Q. So you are talking then about the aftercare appointments, when you saw Patient A. Can I invite you again, Dr Austin, to outline what happened with regard to the manufacturers' instructions on the first occasion that you had seen him?

A. Yes. The key objective is always to try to remove them within as short a timeframe period, which would have fallen within those guidance notes. However, as I explained, he was very reluctant to do so and this was repeated on several occasions.

Q. Again, so there can be no ambiguity on this, what was your advice to him about how long these lenses should be worn?

A. I originally said that we would like them removed on a shorter timeframe and replaced more regularly.

Q. Sorry, on a shorter timeframe than what? When were you saying that they should be?

A. When I originally saw him – as I said, I cannot remember whether I was the one who fitted him originally or not – but I was always of the opinion if I could have lenses out more regularly and that would have been transferred to him at that stage as well.

Q. Again, can I ask you, you have said 'more regularly' and 'in a shorter timeframe'? We have heard – and indeed, seen – that the manufacturers' instructions describe extended wear from one to seven days/six nights of continuous wear. That is the timeframe in the manufacturers' instructions. What was the timeframe you were recommending to Patient A?

- A.** Well, we originally started as we had at that time in that practice at Julian Gunn's a number of people wearing lenses overnight, replacing them every month but wearing them at least weekly, which would have gone within those timeframes. To be honest, it is very difficult for me to remember exactly how many times and what exactly was said at that time. So all I would do is my general practice at that point and I believe that that was the case. I would have put it across in that way.
- Q.** And your general practice you are telling the Committee in that answer was to follow the manufacturers' instructions?
- A.** Absolutely, yes.
- Q.** Now again, I put to Mr Blake various parts of your statement and you start from paragraph 32 at page 7 of the Registrant's bundle to deal with the question of extended wear. Actually, you mention extended wear in paragraph 28. But again, what can you tell the Committee about Patient A's particular requirements and his approach to your advice?
- A.** First of all, the patient attended with amazing low level of unaided vision because he arrived without his spectacles on, which had been issued in the summer. So whenever anything like that occurred, I always thought, 'Well, he's either very motivated or he really didn't like spectacles very much at all'. He wanted to run around with refereeing and so some form of extended wear was pursued because of that. But we did certainly go through discussions and even at that time, we knew lenses in some cases of individuals would have been more complicated than it was for Patient A in the end.
- Q.** And we have heard from Mr Blake that there are risks associated with extended wear and that these should always be carefully counselled with a patient. What steps did you take with Patient A in this regard, i.e. advice on risk and counselling?
- A.** Again, we had a very fortunate period of time and the risks were explained and as I said also in my statement that it is extremely individual which end of the spectrum you are with regard to the tear film, the way the eyes react to oxygen and in some cases, lack of oxygen. So the risk of infection in some patients is higher. However, at the aftercare appointments the notes about the oedema coming in from the tears is actually incorrect; it actually comes in from another part of the eye. The oedema, if it was excessive, would certainly still have been present at a slightly later appointment and the corneal epithelium would have shown other features which certainly would not go away by the end of the day. So whether you saw him at nine o'clock in the morning or five o'clock in the evening, they would still be evident. And, further on, if there were extensive amounts of corneal upset because of oxygenation, then that would also have shown up in subsequent prescriptions.
- Q.** You mentioned earlier, Dr Austin, that you would see Patient A in the morning. We understand from your evidence in the allegations that we are talking of approximately a 15 year period in which he was under your care and that you would see him approximately every two to three months? Is that correct?

- A.** That's right, yes.
- Q.** Again, can you explain to the Committee as best you can in recollection: generally over this lengthy period of time with many appointments, when would you tend to see Patient A? How would these appointments come about?
- A.** It was actually quite difficult sometimes to get him in the standard time that we had put aside for these clinics. But when we could actually ensure that the time was up, he would always come within a few days of that period of time. Sometimes we would see him in the morning and sometimes later in the day. However, the lenses, as also subsequently noted by Nigel Burnett-Hodd actually were – again, because of the individual case – maintained pretty deposit free, which again showed just again in his case the suitability aspect.
- Q.** And in these numerous appointments again over the years, what continuing steps did you take to discuss the issue of extended wear with him?
- A.** At the end of each appointment I would explain to him that he was very fortunate in how he was proceeding and continued to do so again with Mr Nigel Burnett-Hodd. So again, I would try to reiterate any issues of danger and any advice, such as if a red eye occurred, what steps he should take such as phone calls and pathways to get assistance.
- Q.** We do not have your medical records, as you explained, but what evidence are you giving to the Committee as to what you had noted on the records after these appointments?
- A.** I noted that with regard to the cornea and lids and other parts of the front of the eye there would have been a grading schedule made and also at stages in the statement I have gone through a list of questions.
- Q.** What advice would have been recorded by you on the records?
- A.** Sorry, can you redirect – I am not sure what you are asking.
- Q.** What advice given to Patient A would you have recorded upon the records after the consultations?
- A.** Clearly, the notes that I would have liked to have put forward, the issues of eye examinations and referral on that score and that we discussed that other lenses were available – other makes of lenses – but because of the lack of deposits, I felt that this was a suitable product at that time for this very individual case. The use of drops, by the way: again, some practitioners believe drops are necessary morning and evening. Again, they are open to compliance issues too but it was only in the latter period, possibly due to air conditioning in particular offices that this particular patient was showing up a potential. And that was a precaution rather than a necessity, to issue drops at that time.
- Q.** Again in your statement you have explained, as we have heard, that you take the extended wear very seriously and you had only two out of 350 patients in fact on this. Now, you accept, Dr Austin, that you treated Patient A for a

considerable period of time and you accept that you were aware that in fact he was keeping the lenses in for longer than seven days, in fact for sometimes two, sometimes up to three months. Is that correct?

- A.** Generally two months but I appreciate the comment, yes, and I agree.
- Q.** Why did you continue to see and fit lenses for Patient A in those circumstances?
- A.** It had worked up to that date but I appreciate now, in hindsight, I would probably not do so now – well, I wouldn't do so now.
- Q.** We have heard from Mr Blake and we have seen in the manufacturers' instructions that of course there can be risk factors in extended wear. To what extent were you monitoring those factors throughout the period of treating Patient A?
- A.** The risk factors, one of the most common with extended wear, is with regard to the tears that get trapped between the lens and the eye and what can accumulate over time and again in certain individuals, and this is very individual, is a risk of infiltrated keratitis – again the pathway to it is quite complicated. But that is where the risk factor of leaving in lenses longer. However, again, if you remove a lens and you observe the cornea very carefully you would see if these events were likely to have been happening and again, both from myself and Mr Burnett-Hodd, he was a very individual character with regard to the suitability that these events had not been found to have occurred. Again, as I say, without the support of the records, another practitioner, Mr Astbury, had also seen this patient. He was an ophthalmologist and did not see anything untoward. But I appreciate the awkwardness that that cannot be supported by the records.
- Q.** Yes, you don't have the records. Again, I referred Mr Blake to paragraphs 34 and 35 of your statement, which is at page 8 and over to page 9, where you cite from a paper by Fonn et al, which you exhibit and you suggest that the lens selection is far from straightforward. Again, are there any other points with regard to long lens wear you wish to make to the Committee at this stage, in support of your continuing to allow Patient A to use these lenses?
- A.** Yes. It is the situation that though some of the more obvious problems linked to oxygen have been discussed in that paper and other papers linked to that which have been cited, which show that problems linked to the material, particularly those early general high oxygen silicon hydrogel threw up, again in that paper and others.
- Q.** That was talking about the different side effects -
- A.** Absolutely, with regard to the cornea and the disruption to the defence mechanism of the tears.
- Q.** Again, we have seen, I think in Mr Blake's report he suggested that there would be other ways of dealing with it, as there were different requirements for each eye, if I can put it in very layman's terms for Patient A. He also

discussed different lens strengths. Was that something that occurred to you during your treatment of Patient A?

- A.** Yes. The idea of putting one lens of the high oxygen, which was available, because the problems were that for the plus or hypermetropic range they tended only to go up to +6 which would have been insufficient for one of the eyes. So Mr Blake put forward a suggestion of high oxygen disposal in one eye and carrying on with the other conventional lens in with the other eye. The problems with silicon hydrogels – and we are still finding it – is if the lenses get left in for a reasonable time, we are seeing a reasonable amount of lipid, a component with tears accumulation. Again, linked also even with the high water content silicon hydrogels, there is a problem every time the patient is blinking on the lens recovery and its shape.
- Q.** So again, perhaps putting things in very simple terms, it would be fair to say that given those complications that you are aware of, with regard to Patient A to a certain extent it was an 'If it ain't broke, don't fix it' approach?
- A.** I appreciate that. The general comment would be we would do everything we could if it was we felt appropriate. It was not just that. It was that the lenses had stayed phenomenally clear throughout that period. Again, this is supported with the continuance of wear by Mr Burnett-Hodd. Also, that the trial of lenses by Mr Burnett-Hodd into silicon hydrogels, it is not apparent why they were removed but then he removed those and went back to the precision UV lens. So it could well be that it was either a comfort or another clinical issue. So I am saying it is not straightforward about lens selection.
- Q.** We heard as well from Mr Blake earlier – I think he was asked a question by Mr King – about if a patient were to suffer with the effects of a long wear lens would you expect them to return to the practitioner and I recorded his answer in these terms, that he would expect him to call the practice and that a long term lens wearer would recognise anything abnormal fairly quickly. With that background was anything abnormal reported to you by patient A at this time?
- A.** No, it is a phenomenally clear history and that is against audit with Nigel Burnett-Hodd's comments.
- Q.** Again, in your experience, how usual is this sort of scenario?
- A.** With regard to that I have also worked in hospital practice, as Mr Blake has, and we have fitted a range of corneal types and prescription issues, it really does vary from individual to individual. But I think for particularly the time span, this is reasonably unusual.
- Q.** Would you be able for example, in terms of the situation you are describing with Patient A wearing long lenses for the 15 year period and you say the lenses were very clear at that time, for example in percentage terms are you able to say what percentage of your patients you have seen in a similar position?
- A.** With regard to my experience of fitting extended wear to date?
- Q.** Yes.

- A.** We would normally find that if by the end of a month with some patients they were finding that getting a month out of a lens is difficult. Then there are others who would easily get a month out of lenses. So again, deposit loading is quite individual and can be linked to factors linked to their employment and where they are wearing the lenses.
- Q.** And again, in terms of Patient A, when he reports, say, a two to three month extended wear period, how rare was that in your practice?
- A.** In that particular practice, there was only one and that was Patient A. The other one who was extended wear was removed more often.
- Q.** So finally, Dr Austin, so far as you were concerned – and you can only speak for yourself and not Patient A – you have told the Committee that you had made him fully aware of the risks and so forth with extended wear?
- A.** I believe so, yes.
- Q.** I don't have any other questions but my friend may have. Thank you.

Cross-examined by MR WHALLEY

- Q.** Thank you. Dr Austin, you said in your evidence that in hindsight you would not have fitted the lenses that you did fit for that 15-year period. That was your evidence.
- A.** Yes.
- Q.** Why do you say that? Why in hindsight are you saying - ?
- A.** Because I have had a period of time since to consider that point. Since not seeing Patient A and reflecting on it, I appreciate that there were things I would have been discussing differently with him and with regard to retaining him as a patient, I would have stopped fitting him with lenses – purely because of the rules and regs. But from a contact lens physiology point of view, I believe that he was suitable and that has been upheld with subsequent practitioner who has gone through a lot of other tests as well to show that he was suitable for that kind of lens wear. However, personally, I have had time to consider.
- Q.** In terms of the clinical need, you have talked about the 350 patients, two of whom you advised extended wear. You just said in the last part of your evidence that the other patient was removing them much more frequently, so we are really looking at one out of 350 where they were advised – or they were able – with your prescription to continue wearing them for up to three months.
- A.** Yes.
- Q.** Isn't it a fair comment that in fact there was no clinical need? It was really a practical point because Patient A was quite demanding and insistence on what he wanted?

- A.** Again, I suppose it is debatable what we call a clinical need. There are several issues. One is being long sighted like he was, he found actually observing a lens on the end of a finger and handling them quite difficult and maybe that was an issue of getting them in. There are ways of getting round that by actually getting him to put some spectacles on and then removing the spectacles at the last moment. That is how we manage it with a few hypermetropes that we have. The majority of people will be short-sighted who are coming in; that is what we have found, who are wearing anything like this – soft lenses, that is.
- Q.** You must have had other patients with a similar level of eyesight, similar symptoms, within a 15 year period?
- A.** Mainly, as I said, they have been wearing other forms. They have been wearing rigid gas permeable and that because they have worn them for many years longer than he had already. I would have thought actually I had a very small number with that actual demand and handling issue. And they were more persistent maybe to want to get the handling aspect sorted out and get it in their head that that was a preferable thing to do. I thought he was pretty aware of the type of lens wear he was wearing and, as I said, it was continued subsequent to me fitting him.
- Q.** But what I suggest is that the handling issue is perhaps more of a practical point, from Patient A not being able to insert them regularly. In terms of your responsibilities as the dispenser, do you not feel that as soon as you became aware that they were being worn for three months, which is a significantly longer period than the advice and the instructions, you would have stopped dispensing them at that stage?
- A.** Yes. I appreciate your comment and, as I said now, removing the lenses would be a preferable thing to do. It was just the management aspect and please, I don't want to be flippant, but the whole idea of actually wearing a contact lens and the additional risk compared to the very safest pair of spectacles, we could actually question. I do put across that as even the time goes on the options of alternatives to contact lenses, such as refractive remodelling still are not with us even today for hypermytropes at that level.
- Q.** Thank you, Dr Austin. I have nothing further.
- A.** Thank you.

Ms Jeyasingham: Mr Payne?

Re-examined by MR PAYNE

- Q.** Sorry, Dr Austin, just on that last answer you gave to my friend there, you said that you did not wish to be flippant. You were talking about the pairs of spectacles. How were you relating that to the question that had been asked of you of whether there was a clinical need for Patient A to be wearing the lenses that he was?

- A.** Because I had tried other avenues, to try to encourage the compliance to the shorter timeframe of wearing. He was very insistent that that was not what he wanted and as I still brought up that he has been of wearing lenses for longer periods than the timeframe. So whether it was just myself, I am just putting forward the case that that is exactly what this character wanted and I put across the risk aspects to him.
- Q.** Thank you.

Questioned by the Committee

Dr Counter: Can you clarify a couple of things for me, Dr Austin?

- A.** Sure.
- Q.** There was a lot of talk in the last little session about comparison of precision UV as compared to a silicon hydrogel lens and we have already found out that, later on down the track, Nigel Burnett-Hodd tried a silicon hydrogel. Did you at any stage try a silicon hydrogel? I know you don't have the records and it is difficult to remember and so on -
- A.** I put forward the suggestion that there were other lenses which might have higher air flow but, because of the prescription range, I am really quite anti doing one and one, personally.
- Q.** Okay. Could not the option of perhaps – without wishing to get too technical – that he actually restricted his contact lens wear to distance use, putting spectacles over the top, have emerged at any stage?
- A.** Absolutely. It certainly did and again, we found that he would not want any additional spectacles, at all.
- Q.** What about the fact that he was wearing the lenses, not just a little bit more than the manufacturers suggest but that he was sort of 'throwing the book at them' and wearing them perhaps ten, 12 times as long as recommended by the manufacturers? Could you perhaps not have made it a condition of wear that he found an alternative way of inserting and removing the lenses? You mention in the notes somewhere that his partner was capable of doing it in an emergency –
- A.** Absolutely.
- Q.** Could that not have been made a condition of continued wearing?
- A.** It is a very good point and we did suggest whether that could be a possibility but he said that was not always a functioning thing. But certainly the timeframe could have been shortened. I appreciate your comment there.
- Q.** Okay. Fine.

Mr King: Yes. Let me take you back: two out of 350 of your patients were extended wear patients. So is it fair to say, or do you accept that your experience in extended wear use was fairly limited?

- A.** That was within that practice and that was at the time we finished. However, some people had tried them and, for various reasons, found that actually returning – and even still today we are finding that daily disposables are still the most common. But with regard to experience –
- Q.** Extended wear rather than daily -
- A.** Absolutely. As I said in my statement, I have been in hospital practice where the firmer lens is fitted through a very extensive number of months and here, in Westminster, with Jonathan Kersley. So yes, certainly seeing extended wear events of all the form that the expert witness put forward, I have certainly seen.
- Q.** So you would say then you were pretty competent at fitting extended wear lenses at the time of fitting Patient A?
- A.** I believe so, yes.
- Q.** Okay. So why would you deviate – this is what I am trying to understand – so much away from the manufacturers’ guidelines of one week, knowing full well that, in your opinion obviously and degree of competence, the amount of oxygen getting to the corneal surface is going to be significantly reduced – why would you accept two to three months’ wear?
- A.** Purely in this particular case with regard, as I said, to corneal epithelial and other nerve or deeper structures, there really was no evidence of corneal oxygenation issues, in this particular case. But I appreciate your comment that I suppose I was driven to be encouraged to do so. That is exactly what he wanted for longer periods. But I appreciate your comment, yes.
- Q.** Can I just push this a little bit further because, when you were supplying precision UV lenses, they were being supplied in packs of three or six?
- A.** Yes, either form.
- Q.** So tell me, how many packs or pairs were you supplying at each visit?
- A.** Generally, we would have given him a pair and a spare. So we would put a pair in so he would probably have had boxes of three at that time.
- Q.** All right. So let’s just try and understand that. You say you would put a pair in. So you would insert both lenses into Patient A during the -
- A.** Yes, at the end of the appointment.
- Q.** Did you not put any fluorescein in that person’s eye as a matter of routine?
- A.** We would but by the time, by putting very small amounts in, it was certainly not a problem by the end. Because I would have done things like topography and other tests and discussions at the end, so the fluorescein was not really an issue with uptake.
- Q.** Okay. So you would then say, ‘All right. Here’s a new pair of lenses for you, Patient A’, and you have personally inserted those lenses and you are giving him a spare pair at that stage? Or one spare lens?

- A.** I cannot exactly remember but I remember we had them in the boxes of three for him.
- Q.** What I am trying to get to the bottom of is, you would get a box of three through, every three months. Yes?
- A.** Yes.
- Q.** Those boxes come in a particular power. In other words, they are not mixed powers. His lenses are very different, one eye to the other, so you would have three pairs of lenses every three months to supply to him and you are saying you are – what? Breaking the boxes up and giving him one pair that you insert and a spare pair to take away for a three month period?
- A.** I believe the boxes were issues as well. I can't remember, honestly, if we gave him two or one lens, to be honest, at the time.
- Q.** Because I am struggling with trying to understand. Firstly, we have discussed whether you strayed wildly away from the manufacturers' recommendations. The lenses are coming through in boxes of three or six, because that is all you could purchase them at, at the time. Yet, he is still wearing them for three months, one pair of lenses. It does not tie in.
- A.** I appreciate that, no. As I have said to your colleague here on the Panel, we did try encouraging more frequent replacement. However, as I said, the clinical – overall the lenses were very clear.
- Q.** So you are condoning his wear by saying because the lenses were clear and there were no clinical results and he did not actually report in any particular form to either the hospital or yourself his issues, then everything was fine?
- A.** I also appreciate the length of time, yes.
- Q.** Were you aware that he had glaucoma in the family?
- A.** It was discussed, yes. And as I said, he did see an ophthalmologist in the 1990s and I have on a number of occasions tried to fit him in with a practitioner. But it was one of those things and procedurally, I appreciate I did my best to encourage him to try and see another practitioner – well, an optometrist or an ophthalmologist.
- Q.** Okay. I'm trying to understand your grading scale as well. In other words, Mr Blake rightly pointed out that there was no reference to the grading scale. Is this something you have created yourself? Is this a universal scale? What is this grading scale that you are using?
- A.** No, it was the CCRU scale.
- Q.** Why was that not inserted on any of the records?
- A.** On the supplied note – yes, I saw it was not there but subsequently, verbally, I did speak to Nigel Burnett-Hodd about this.
- Q.** The other point you return to on a fairly regular basis is the fact that after Mr Burnett-Hodd tried Oasys lenses in this particular patient he returned to PUV

as some sort of vindication that therefore, everything was fine with that particular style of lens. Is it not your experience that people going from a hydrogel lens to a silicon hydrogel lens quite often can get issues?

A. Absolutely, yes.

Q. Especially if they have had long term wear and especially if they have been wearing them on an extended wear basis?

A. I would not know that that particular group would have been – I believe they can have complications because of the silicon component, yes.

Q. Right. Many thanks.

Ms Jeyasingham: Dr Azubike?

Dr Azubike: Just one point I would like to ask him: I want to explore the difference between having an appointment first thing in the morning and having an appointment later in the day. What is your evidence to this Committee with respect to what advanced kind of reactions you want to detect in the eye?

A. If there was extensive oedema, above between 8 and 9 per cent and the formation about two-thirds into the cornea, if there was excessive fluid entering from the back of the cornea, which is really where oedema occurs, then there can be disruption to the formation of certain anatomical features. Then if the eye de-swells during the day, the thought is that they would dissipate and would not be visible if you saw the person later in the day. However, as I said, I did see him both morning and at other times in the evening. There was no issue with those formations of stria faults. The point about the microcyst is that this is known to be a very useful test with regard to seeing if the epithelium is actually being sluggish with regard to regeneration and again, the numbers were within normal limits of very few numbers less than ten, which was also important.

Q. Thank you.

Dr Counter: Just one more - sorry to come back at you, Dr Austin, but you mentioned Patient A seeing Mr Astbury at some stage or another. I know without the records this is more difficult, but is this referring to his eye examination before starting on contact lens wear, or during contact lens wear?

A. No, it was during lens wear.

Q. You referred him on, presumably?

A. We worked together, as I said, on Saturday mornings, so that fitted in with Patient A coming up from London. Again, I apologise for the lack of records but, because it was such an individual case I believe he was seen more than once but again, I can't give you the year or date. But that would have both been for pathology and for the vision aspect.

Q. Right. So it would have been a full eye examination?

A. Absolutely, yes.

Ms Jeyasingham: I have a couple of questions. You mentioned that there were drops in the morning and the evening? Can you explain a bit about that?

A. There are different schools of thought, whether we ought to be putting drops in when the person wakes up and before they go to bed with the lenses in, with regard to the potential of sweeping away. So it is a bit like having an excessive number of tears and making a flushing action. Also, Mr Blake brought up the idea that some patients would accumulate problems due to the front of the lens rubbing the eyelids. But again, that is a very individual thing and it is probably allergic in origin and again, in this case, that was not present.

There are some schools of thought that while the eyes are closed and the lids going over the lens, the eye will be more comfortable. However, the other school of thought is that if the lenses are staying clear, then you could actually be reducing the anti-microbial content of the tears, in favour of flushing. Again it is individual and as I said, because we are changing office that was thought to be why we suggested the latter end.

Q. So, just to clarify that, he was using drops, was he?

A. No, just at the end, purely because of what I perceived as dryness. However, again it is complicated with regard to whether it is truly dryness or other features. And the concept that there is an increase in salinity of tears is debatable. It probably does not happen once a person has established wear, the number of the tears are fairly consistent high in contact lens, during lens wear, once the lens has settled in.

Q. Right. And just back to another thing – I think you have answered this in a number of ways – but about his inability to put his contact lenses in, or take them out and put them in: you would have explained it to him and presumably demonstrated it to him? I am just wondering how much instruction patients usually need in those sort of circumstances?

A. It varies from individual to individual. Manual dexterity, being able to see a lens unaided, but we had some very good clinical assistants who are very experienced and on numbers of occasions we would need people back quite frequently for more than one visit. So we would rather they went away confident than not confident – or competent and confident.

Q. So what happened to Patient A then? Would he not take instruction? Or was he just unable to - ?

A. No. He came back a number of times to try and as I say, the lens removal which I believe is really very important, being able to get them in and out means that generally the frequency is more competently covered, yes.

Q. A final question about the fact that the notes went missing in the move, when you cleared out of the practice in 2006 -

- A.** It was actually when we moved house. We had two removal companies, both with secure stores.
- Q.** So what was the date of that?
- A.** That was August when that occurred. We had two times when things were collected, purely because of the logistics of getting things boxed up and what you could live with until the actual move occurred.
- Q.** I just wanted to know how recently you had read his notes, because obviously over a 15-year period remembering one particular patient during that time must be difficult. But you seem to have quite a good recollection of what was done and what was not done.
- A.** My only defence on that is that he was very different from many of the others I had. I do often get congratulated on what I remember about people; maybe not their notes but certainly characteristics, yes.
- Q.** Okay. If there are no other questions you can step down, thank you, Dr Austin.

[The witness stood]

Mr Payne, are you introducing any other evidence at this stage?

Mr Payne: No, Madam, not at this point.

Ms Jeyasingham: So we are going into submissions. I realise that we have been going now for a couple of hours. I don't know if people want to do submissions and then we go to break? Or is it better for us to take a break?

Mr Whalley: Madam, whether to continue or not, I have nothing further to say. I opened the case, there is a very discrete point on Allegation 5, there is nothing I can add to what I said then.

Ms Jeyasingham: In which case, we will keep going. *[Confers]* You actually want a break? In which case, maybe that suits the Panel, to have a very short break and perhaps we can come back to hear the submissions in – ten minutes?

[Hearing adjourned at 11:53]

[Hearing resumed at 12:05]

Ms Jeyasingham: So, we are ready for submissions.

Mr Whalley: Madam, I said I would not be making any further submissions. I will make some very brief comments on the evidence. Of course, at this stage

you are considering the factual allegations only and indeed, the one remaining factual allegation in dispute, Allegation 5. Sections of that allegation are admitted; the section that is not is about the clinical need for such extended wear. Dr Austin accepts that the lenses were being worn for up to three months and he was aware of this when Patient A was coming back for the check ups. Kevin Blake was very clear in his evidence on that particular point. He said there was no clinical need in this case for Patient A to be wearing those lenses and being allowed to wear those lenses for up to three months. On that point, he was very clear in his evidence.

Dr Austin, you will recall, to an extent accepts that. He says in hindsight he would not have prescribed these lenses and therefore, in my submission there is an element of acceptance of Dr Austin that he would have done things differently now. In my submission the Council's case is very clear and indeed is supported by the evidence that there was no clinical need for this in terms of that very specific point, the clinical need. It was a situation where Patient A was a very demanding gentleman, insistent on what he wanted but, in my submission, that should not prevent the practitioner using best practice and making sure their duty of care towards the patient is upheld. In this case, that would have been done if closer monitoring had been undertaken of Patient A and indeed, he could have been enforced to follow a shorter period of wear by simply dispensing fewer contact lenses. As soon as he became aware that they were being worn for three months, in my submission at that point more should have been done and a different approach should have been taken.

Madam, that is all I wish to say in terms of my submissions on the facts stage.

Ms Jeyasingham: Thank you, Mr Whalley. Mr Payne?

Mr Payne: Thank you. As my friend has said, as we indicated at the outset, the continuing to dispense part of this allegation, of course, is admitted and the manufacturers' instructions clearly are admitted; they cannot be gainsay-ed. But in terms of the clinical need for such extended wear, as my friend says, it is the decision for the Committee on the facts but, to a certain extent it would be swaying over, I think, inevitably into a judgmental matter because it involves decisions taken by a professional with regard to a treatment regime .

We have heard from Mr Blake as to his views upon the matter in his written report but we have heard from his evidence as well and I will return to that in a minute. First, to deal with my friend's submissions, he has cited Dr Austin saying that in hindsight Dr Austin would do things differently, which of course is something that he did say. That does not mean that in fact what he did upon this occasion was clinically inappropriate or wrong. It is really a recognition that, as in so many walks of life and professional walks of life, there are what I have described as a reasonable range of responses, a reasonable band, within which individuals can be treated. It is submitted that those comments of Dr Austin should be located in that sort of framework.

My friend said that Mr Blake's recommendations for this should have been followed and that would have enabled the duty of care to the patient to have been upheld, i.e. refusing to see him unless it was clear that he was using the lenses for a short period of time. Again, it is submitted on behalf of Dr Austin here that it is not the duty of care in that sense that is being looked at, because Mr Blake praises Dr Austin in his report for the frequency of the aftercare appointments, every two to three months. He saw him a lot and, as we have heard from Dr Austin's evidence, he was aware of the risk factors to be looking for. He examined Patient A upon this frequent basis and found no traces of problems such as, to a certain extent, the problems that were to later arise, and no real contraindications, which would indicate to him that the usage was inappropriate.

Madam, members of the Committee, with regard to the clinical need, Dr Austin essentially says that, as you have heard – and again, I urge you to look at the appropriate parts of Dr Austin's statement as well as taking into account the oral evidence that you have heard – in essence each person is an individual, self-evidently. The condition of their eyes, the pressures and so forth, the conditions that we have heard about, will vary and the reaction of individual patients, clearly, self-evidently, varies to different parts of treatment and different lenses. Dr Austin has indicated that in this case we have heard the particular regime was something that worked for Patient A. Dr Austin has also made it clear that he advised at the outset that Patient A should indeed follow the manufacturers' instructions and so forth. You will note that in Patient A's statement, he describes how he was given fitting sessions or he attempted to learn fitting sessions from Dr Austin as well.

In his second statement, certainly, he accepts that he may well have had instructions – of course, he is not here – and makes comments about whether or not they should be read. But it is submitted that there is nothing to gainsay what Dr Austin says here, which is that when he provided the lenses initially there was a detailed discussion about matters. He was fully aware of the risk factors and he put those across and Dr Austin went further and said that, of course, this would be reiterated at the subsequent appointments, which we have heard were of some considerable frequency over the years. Of course, at those additional appointments, there would have been further prescriptions given. The lenses would have been given out again each time with the manufacturers' instructions.

So the evidence of Dr Austin is that he was aware of the risk factors of long lens wear, that he had discussed them with Patient A and that Patient A, for the reasons – I would submit both clinical reasons in terms of that they were assisting him in the fashion that he wanted in a fashion that was not having negative effects upon his eyes at the time that he was being treated by Dr Austin and also for the other factors, the difficulties he had personally with insertion and removal and so forth. Patient A was most insistent that this was appropriate for him and he wanted to be treated in this fashion and insisted upon being so treated, despite having been made aware of the risks.

Again, with regard to this specific part of the allegation, I refer you – the Committee will have their own notes but I recorded Mr Blake concluding his evidence when I was questioning him and talking about the risks of the long lens wear and so forth and my notes of his response – it may not be verbatim – was to the effect that, talking about the risk, ‘As long as it is noted on the records, the patient can carry on as long as he is aware of the risks’. In other words, implying that there are individuals – and he accepted, you will recall, that he made perhaps light-hearted comment about some contact lens wearers being a different breed - who are difficult, who are not run of the mill. In that circumstance, he said, ‘As long as they are made aware of the risks and that they then take responsibility, as it were, for them, then they can carry on’. It is submitted, he also said in answer to Mr King later on, that he would expect a long lens wearer to immediately notice any changes, any deficiencies, any deterioration in the condition of the eyes and so forth, particularly a long lens wearer and he would expect them to report back to their practitioner.

You will recall that, upon that point, Dr Austin was absolutely clear that there were no reports of any problems throughout this period of time with the long lens wear reported by Patient A. In fact, I think that is consistent with Patient A’s witness statements before this Panel, where he does not recall during the period of 1991 to 2006 there being any difficulties.

Madam, members of the Committee, taking into account those points, it is submitted that when you also hear what Dr Austin has to say, the evidence is that Dr Austin had made this individual, Patient A, aware of the risks from long lens wear. He was aware of the manufacturers’ instructions and in fact, this gentleman was one of that rare breed of those who were determined to go ahead and accept the risks and continue in any event and perhaps over the passage of time, did so because we are not just talking a few months here. We are talking of a very significant period of time that there had not been deleterious effects upon his eye health whilst being treated by Dr Austin, or none that he had reported. Therefore, so far as he could see he certainly had the opportunity to assess that risk over a considerable period of time.

In that regard, it was clinically appropriate, the risks had been made clear, again, inviting the Committee to take into account the points that were made during the questioning and the evidence of Mr Blake and indeed Dr Austin. Furthermore, I think Mr Blake’s report describes that there would need to be exceptional circumstances to depart from the norm and the manufacturers’ instructions. I have already dealt with departing from them where one would have counselled a patient as to the risks and the patient, in effect, takes upon board the advice and either chooses to accept it or ignore it. So that is one element of it but the second part of it, in turning to ‘exceptional’, ‘exceptional’ in its general English usage, it is submitted that in the context of Dr Austin’s evidence here, we are talking two patients out of 350 had extended lens wear use, which is less than 1 per cent of his caseload and of those two, as we

have heard, there is only the one individual, Patient A, who used the lenses in this particular fashion. Equally, not only is that the very fact that it was just one individual would make it, it is submitted, upon any reading exceptional but in fact, the reaction of – or the non-reaction perhaps would be a better way to put it – of Patient A to the long wear usage would again make this an exceptional case whereby various things, particularly the ulcerative keratitis and so forth that were warned as contraindications of extended use wear, were not issues. There weren't other contraindications during the period of Dr Austin's treatment of Patient A.

Again, in the general context of his practice, not just at Julian Gunn and at Perfect Vision in Diss, but as we have heard from Dr Austin, he had had other experience in hospitals and so forth with extended wear but in his career, this does stand out as being a very rare case, in that sense, it is exceptional.

So the second strand of the submissions upon Dr Austin's behalf would be that, given that this is for those reasons an exceptional case, therefore again it would have been clinically appropriate. There would have been the clinical need for Dr Austin to have treated this gentleman the way that he did.

So, members of the Committee, unless there are any other points that I can clear up for you, those would essentially be the submissions on Dr Austin's behalf on this point.

Ms Jeyasingham: Thank you, Mr Payne. I turn now to our Legal Adviser, Ms Whittle-Martin.

Ms Whittle-Martin: My advice at this stage of proceedings will be very brief, in the light of the very limited factual issue that you now have to resolve. As you know, you are judges of both law and fact; it is not for me to influence you or seek to influence you on your decisions of the facts. The facts as have been set out are alleged by the GOC and it is for them to prove them. The burden rests throughout on the GOC and that means that the Registrant does not have to prove anything and in particular he does not have to disprove what is alleged.

Furthermore, as you have been told, the GOC must treat those facts on the balance of probabilities. A fact, put simply, will be established on the balance of probabilities if it is more likely than not to have happened.

Finally, I think the only other area in which it might be helpful for me to give some advice is in relation to the concept of hindsight, which has cropped up. My note of Dr Austin's evidence in relation to this part of the case suggests that, although he accepted he would act in a different way today if he were to be in the same situation, he qualified that acceptance by adding these words:

“Purely from the point of view of the rules and regulations I would do it differently now”.

I hope my note is correct in that regard and, if it is not then I will gladly be corrected but, if it is correct, then his answer might have rather less significance than has been suggested in fact by both sides in the course of submissions.

Unless I can help you in any other way, that is all I would say at this stage.

Ms Jeyasingham: Thank you. In which case, can I invite the Hearings Manager to clear the room? As we are coming up to lunchtime, I think it is appropriate that we probably will not make a decision before lunch so we may as well take the lunch hour and come back by –

Mr Henley: Is everyone available for two o'clock, say?

[Hearing adjourned at 12:20]

[Hearing resumed at 14:00]

Ms Jeyasingham: I am going to read out the findings in relation to the particulars of the allegations.

Findings in relation to the particulars of the allegations

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:

- 1) A difficulty that Patient A claimed to have with the insertion of his lenses; and

- 2) 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.

In which case, can we move on now to deficient professional performance and/or misconduct?

Mr Whalley: Madam, on behalf of the Council, I will be presenting no further evidence on those points, they are matters of judgement. I will make some submissions but there is no separate evidence on that point.

Ms Jeyasingham: Therefore can I clarify that you are not bringing in any further facts?

Mr Whalley: No, Madam, thank you.

Ms Jeyasingham: Mr Payne?

Mr Payne: Madam, safe to say, as my friend said and in advance of hearing from Mr Whalley, and on behalf of Dr Austin, given the four admissions in the findings, it would be submitted that those would be tantamount to deficient professional performance, as opposed to a misconduct, and that would certainly be admitted. If the Committee takes a different view, or if Mr Whalley takes a different view, then I am happy to address you on submissions upon that point, but certainly those are the admissions and the submissions on Dr Austin's part at this stage.

Ms Jeyasingham: In which case, I will turn to our Legal Adviser.

Ms Whittle-Martin: Madam, the position is that it would be for you to decide this point, so my advice would be to continue through to the next stage and hear submissions from both sides and any evidence that Mr Payne may wish to call and then hear advice from me.

Ms Jeyasingham: In which case, shall we move on, then, to impairment?

Mr Whalley: Yes, Madam, perhaps if I can address you in relation to deficient professional performance, misconduct and impairment? If I can do that in one process then it might be smoother. However, I am aware that Dr Austin may be giving evidence again on the issue of impairment and that is probably right.

Mr Payne: It is my intention to call Dr Austin again in terms of impairment and obviously for him then to place into evidence the mitigating factors and so forth which are in the Registrant's bundle. Obviously we have dealt with the certain matter of the long use lenses and I would not intend to trespass on that area again; the Committee has heard at length on that. In relation to the other mitigating factors contained within the statement – obviously the statement is relied upon but there may be further evidence which Dr Austin would wish to give.

So, if you consider it is appropriate from him now – I am in your hands.

Mr Whalley: Madam, I am also in your hands. I can make submissions now on both matters, or if you would prefer, you can hear from Dr Austin and then I can make submissions at the end.

[Committee confers]

Ms Jeyasingham: I think it might be better to hear from Dr Austin first. So could you take the stand, please, Dr Austin?

**DR AUSTIN, recalled and re-affirmed
Examination-in-Chief by MR PAYNE**

Mr Payne: Dr Austin, I again, just for the record invite you to confirm: I understand that your statement in the Registrant's bundle is not signed but the Committee has seen your signature and you confirmed that that is your statement earlier. Could you just do so again and indicate that you will formally adopt that statement as your evidence?

A. Yes, if this is the last statement that I wrote, I agree to this statement.

Q. As indicated, Dr Austin, I don't intend to deal with matters that you dealt with in evidence this morning and of course you have admitted four of the allegations against you and had the other one found against you.

Can I ask you – you have dealt with this in the statement – given that you have said that this is one individual, why do you think that your standards have lapsed on this occasion?

A. It is very much a particular case. I feel that I was heavily persuaded maybe and I took persuasion to the admission of carrying on. So, as I would like to put forward and emphasise, I am very disappointed for Patient A and for all the trouble that it has caused, particularly to my family, over the three years that this has been going on, pretty much. In answer, when I said to your colleague here, Mr Whalley, when he asked the question about whether I would do it again, what I am saying is that I would not be doing it again. This is a heavy persuasion that this person particularly wanted this style of lens and when I said that I would never let it happen again, I would never let anybody go through this – including myself and my family and colleagues etc.

- Q.** You have mentioned, of course, that you are sorry for what has subsequently happened to Patient A. Again, in terms of Patient A, have you taken any steps to contact Patient A and/or express anything to him, since this came to light?
- A.** I did not directly, but through the Council I did apologise in an email to say that I was very disappointed that this had occurred and that the Patient had gone through this with regard to the outcome of needing to see Patient A's care.
- Q.** In terms of the requirement to have a sight test, we have heard it is two years – Mr Blake said this morning that that would be the maximum period but it could be once a year, depending on the patient. What can you tell the Committee about that and any lessons that you have learned with regard to that particular point?
- A.** Again, I can give assurance that I completely agree that the time period is important and it is nearly inexplicable as to why this continued. This was one of those cases where I said things and said them procedurally, but though I might have said them, I did not see that he carried them out, so I believe that this was the difference between not mentioning it. As Mr Howard said in his statement, we did make provision; however, I did not procedurally follow those through.
- Q.** What is your understanding of the potential consequences of not following those through and of a patient not having a sight test with the due frequency?
- A.** I whole-heartedly agree that the whole aspect of the whole patient care is important and I explained about the requirement for other tests, but again, maybe I did not make it as obvious as I should have done and very bluntly obvious as time went on.
- Q.** Again, sorry I am not sure if that answered my question, which was what is your understanding of the potential consequences to a member of the public if the tests are not undertaken?
- A.** Well – depending on the problem involved – it can have awful consequences.
- Q.** Can you spell that out a little more, please?
- A.** It can lead to catastrophic situations such as blindness and certainly having the tests which I did outline and explain to him needed doing, problems such as those with the retina, visual field plots etc. I went through those and I said that these other tests should be undertaken.
- Q.** And likewise, in terms of the eye tests, the other allegation that you have admitted, of those allegations that are proven, is that 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.”

- You have admitted that, again, can you explain why that did not happen?
- A.** In most cases, we have a regular thing of seeing a patient annually – and everything at the very longest, annually, for their aftercare. It is normally at that point – it is the frequency of the visits which made it difficult to decide when, again, with regard to Patient A. So, we had a procedure to issue these out when the lenses were issued in standard patient groups.
- Q.** So you had a procedure to issue them out but that procedure was not followed with Patient A?
- A.** Yes, as I said, because we saw him sometimes up to as much as six times a year, it was difficult to demarcate those periods and again my feelings now would be that if ever something happened where patients were coming in frequently, we would make a standpoint of when they need to be re-issued which is within the legal timeframe.
- Q.** Likewise, Allegation 4 was admitted and this was that:
- “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.”
- A.** Again, as I did say, there were periods when we did have that organised, but again without the patient records. However, even so, there were periods of time longer than two years, which I appreciate is outside what would be an accepted period.
- Q.** Now, to a certain extent you dealt with the records earlier and you explained then and you also explained in a statement that this came about as a result of you moving house or business practice, is that correct?
- A.** No, basically the requirement within Perfect Vision was actually associate style practice and the records are actually locked away in a home office environment.
- Q.** Again, what is your awareness of the need to keep and maintain patient records?
- A.** For confidentiality the need is to keep them safe and reviewable within the required timeframe.
- Q.** And this is something of which you were aware in August 2006? Is that right?
- A.** Absolutely, yes.
- Q.** How would you describe your state of knowledge and awareness of these requirements today?
- A.** That the required period of time is stipulated for the safe keeping of records, even if the patient is discontinued under your care. So, I am fully aware.
- Q.** I invite you really just to clarify this – it is in your statement – that although a number of personal items as well went missing with the removal company and

you attribute that to the loss of Patient A's records, you accept personal responsibility?

A. Absolutely, yes. It has happened to relatives – I appreciate very closely how important it is having medical records kept. In my uncle's case, they were lost and he developed cancer through it, so I am extremely aware and very disappointed with that happening as well.

Q. Thank you. Now in terms of the rest of your practice, in which you were involved at the time, in 2006, when you wound it down and transferred to academia, had any other concerns been expressed from any other of your patients?

A. No, I have spoken to my colleagues and some of you may have seen that some of the colleagues have taken on the patients, and there was not one case where there was any discomfort with taking on a particular patient.

Q. Sorry, can you clarify that – there was not one case where there was discomfort?

A. From colleagues in terms of what was going on and the procedures that had been undertaken, yes.

Q. To what extent had any of your other former patients, apart from Patient A, expressed any concern with your former services?

A. Not of which I am aware, no. Not directly to me, no.

Q. You are not aware of anybody?

A. No.

Q. We are talking about allegations between 1991 and 2006; to what extent did you face any other complaints about your ability during that timeframe when you were practising?

A. From colleagues or from patients?

Q. From patients?

A. None at all.

Q. Or from colleagues?

A. None that have come through to me.

Q. Since then, since being in academia, in 2006, can I ask you the same question? Have there been concerns expressed by patients or colleagues about your work?

A. No, if anything it is the reverse. Generally they would come to me for advice rather than the other way round. That includes the Anti-Myopia Trial, which was an extensive trial and I was asked to come in and discuss some of the lens materials and designs that they were using.

- Q.** In terms of future protection of members of the public, perhaps I should ask you to clarify for the Committee's benefit the current extent of your contact with members of the public, as you are an academic?
- A.** Yes, this continues with undertaking student clinics, with regard to inserting and removing lenses with students. I work with an optometric colleague but often in areas which are in different environments or two rooms or two teaching lanes. I come in and also take some of the specialists to the public clinics, when we have complex cases coming in, such as from Addenbrookes Hospital. In addition we have carried out a series of extensive trials for companies. One is an example with Abigail Holland who is in the witness pack or the support pack.
- Q.** Can I ask you just to go back a bit? You said that you do work with students, can you clarify for me: are you fitting contact lenses on the students themselves? Are they the guinea pigs, as it were, for learning purposes or do you have members of the public come in?
- A.** For both optometry and dispensing students. For the optometry students we take it slightly one step further, because the course for dispensing students is an introductory course, but we are the only University which actually takes a student through what would go through as an original or a pre-fitting routine for dispensing opticians, so we take them through that record card and as a practical clinic they actually sit in and work all the instruments.
- Q.** You have mentioned your record card. Could you turn to page 41 of the Registrant's bundle, page 24? Have you found that, Dr Austin?
- A.** I have, yes.
- Q.** Again, can you explain to the Committee what this is and how it came into being, please?
- A.** Yes, since pretty much the time I finished with Patient A I took over the role within the British Universities Committee of Contact Lens Educators and part of it was with a group at Dublin; I put together and developed this for student teaching. So this is mainly composed by me particularly for the latter part with regard to getting the students to think about the questions which might come up, and referral. So it was developed really around 2005 and 2006 and continued with updates. As you can see, it has been updated with the new core elements at the top there.
- Q.** How would you relate this and your teaching involving this sheet to the failings that you have admitted before this Committee?
- A.** I think that one element would be the element of lens choice, which is on the second page in, where the students might ask a series of questions which is really covering page 41 [of the bundle] and the proceeds onto page 42, where there is that basic information in terms of what kinds of things would be thought about as an appropriate lens choice? Really that is a series of questions as to what is available and what is permissible.

- Q.** In terms of the matters that you have admitted with regard to the need for the regular sight tests and spectacle prescriptions and so forth, what part, if any, do those factors form in your teaching?
- A.** In a series of lectures, but also, when we are in the contact lens clinics, the students – particularly optometry third year students – we discuss elements of length of time and again, also with some of the dispensing students who we have had in the past, who are doing their actual contact lens qualification – that course is no longer being run at Anglia.
- Q.** Again, is it the case, just to be absolutely clear, that these requirements – regulatory requirements of tests and prescriptions – are matters that you teach to your students?
- A.** They are indeed, yes.
- Q.** Those are matters of which you tell this Committee that you are fully aware?
- A.** Yes, absolutely.
- Q.** Now what reassurances can you give to this Committee that going forward the matters that you have admitted would not be repeated?
- A.** I think, with regard to following procedure, with regard to not being persuadable in the way of the patient going beyond timeframes or permissible limits, would just not be tolerated. What I have learned in the three years over which this has been pretty much going on – which as I say, has been phenomenally stressful – I have encouraged students, along with myself, to realise that if a patient follows a route of action with which you are not comfortable, it is important that you cease proceeding. Certainly I have learned that.
- Q.** That answer, then, chimes broadly with the evidence of Mr Blake's report where he suggests that dealing with problematic patients, the best way can be not to continue prescribing until they have followed your advice?
- A.** Yes, it was unfortunate, as I say, and I agree completely that if they are not following the rules or what you believe should be the right mode of direction, that we should stop that direction.
- Q.** You said there in your last answer – and you have indicated that Patient A was a forceful character – but again, what guarantees can you give that you would not allow yourself to be swayed by a forceful personality in the future?
- A.** Certainly with what I have learned to date, that would not occur and I would just say absolutely and straightforwardly to them that this is just not going to happen.
- Q.** Since 2006, when you went into academia, you have given one example of the matters that you have done with reference to your clinical sheets which we have just referred to the Committee. Could you also tell the Committee about other ways in which your education has continued?
- A.** Yes, I am a Fellow of IACLE which takes several hours of an examination to complete and I regularly contribute to IACLE with regard to educational

material. I also completed a PhD which explained many of the facets required for a silicone hydrogel to work on eye and if those are not in place, I worked with Coopervision to assist them with a requirement about one of their materials, as to whether it would be clinically acceptable. I have worked with Bausch & Lomb, again with regard to materials and characteristics necessary for making sure that they are clinically acceptable.

- Q.** Can I ask you to spell out the abbreviation that you gave there?
- A.** IACLE - as opposed to a British qualification group, this is an international qualification and group – there are about 30-odd members of Fellow stature in Europe. We get together to try to push forward improvements in student engagement and improvement in education.
- Q.** What does it stand for, please?
- A.** International Association of Contact Lens Educators.
- Q.** You mentioned your PhD, when was all of the study and work done for that and, again, when was that completed?
- A.** That was the main reason for ceasing work in 2006, because as a part time graduate student, it was just impossible to combine the two, so the main period of study was 2006 to 2009 with elements before that, in terms of requiring data, but the main part of the PhD was written up, pretty much on my own, from 2006 to 2009. That was actually examined by Professor Brian Tye and Dr Carole Maldinardo-Codina of Manchester.
- Q.** Again, in terms of your continuing obligations with regard to continuing professional education and so forth, how do you ensure that your obligations there are met?
- A.** I continue through CET – Continuing Education and Training. I give lectures as well. I also engage with colleagues with regard to practice and procedural methodologies. So we are looking at new tests for the tear film, for example; we also have a new slit lamp microscope being developed, based on design, but I cannot tell you any more than that.
- Q.** So from what you have said, it is a fairly continuous process?
- A.** Absolutely, yes.
- Q.** You mentioned earlier the work that you did within the industry project; was that with Abigail Stott?
- A.** Yes, she was Abigail Holland before, sorry.
- Q.** I don't know if these are in your bundle, my colleague prepared this, we had some character references?

Mr Whalley: Yes, I have them, they were not submitted as part of the agreed bundle but they were not used at impairment stage so they are not with the Committee.

Mr Payne: Maybe they are not with you at present, but you mentioned earlier Abigail Stott who is a Project Development Manager for UltraVision. You mentioned it in passing but can you perhaps just explain the work that you did with that company, please?

A. I can to some extent give a summary.

Q. In brief terms.

A. Yes. Abigail joined us under a Knowledge Transfer Partnership and we were chosen because of certain expertise with regard to clinical and contact lens materials. I was chosen to lead the project with colleagues, Shahina Pardhan and Sheila Rae. The project was a two-year long project and the idea was to do a direct lens comparison trial and the project took some time to initiate because of external funding and the time that it took to get the grant from the government and industry set up. So, we had to change direction, but overall, the idea of the trial was to undertake a full clinical trial, comparing two different hydrogels, two different silicon hydrogels and completely look at things like vision, comfort and bio-compatibility – the suitability of the lens being in the eye. This required setting up the full ethics approval, setting it up fully, making sure that the subjects knew what they were taking on. As I was Trial Director, I had to make sure that these were in place and this continued from, I believe 2009 when it – or the end of 2008 onwards, actually, for two years.

Q. Again, are there any current projects that you would wish to continue doing? Are there any projects that are in the pipeline at present?

A. Yes, I am Senior Supervisor for a PhD student who is reviewing dry eye. We have cited how complex or complicated staining can be and we are not sure whether staining is to do with dryness or other issues, so we have two elements that we are looking at, with one PhD student with me and another one with somebody else and this is, again, to try to converge our ideas and hopefully gain a far better idea and give advice to colleagues.

Q. Again, just to take you back, Dr Austin, to the situation and the allegations admitted with regard to Patient A; these are dealt with at page 14 and page 15, Madam, of the Registrant's bundle. Again, you say, at the bottom of page 14, paragraph 70:

“From the moment I received these allegations, I have thought long and hard about how or why I made these errors. I appreciate the impact on the public when errors such as these are made in practice. In particular I have considered why I continued to supply [Patient A] with contact lenses despite not having an up to date sight test. This did not happen with any of my other patients.”

You said that it is difficult for you to explain and you refer to the forcefulness of Patient A's character. Are there any other factors that – looking back on it now – you would wish to mention to the Committee? Are there any other explanations that you can give for this?

- A.** There were some personal issues, but I would rather not bring those up now. It was a very stressful period at the lead into the 2000s, because of the taking up of the PhD. It is not a straightforward concept and added to that there were other issues around neighbour disputes and we can supply documentation for that, if that is required. There were a great deal of things going on, so I was certainly distracted in this case; however, that still does not put away the fact that procedurally, there were issues.
- Q.** We are talking obviously over a period of 15 years in terms of this going on. You also say at paragraph 72 that you have been in the industry for over 30 years and have had an unblemished career up until this point, and you are inviting the Committee, are you not, to see this as one – albeit extended – mistake, is that correct?
- A.** Yes, I dispute the 15 years, because I have explained that because of the very individual character he was, we certainly did see him within the 15 years, I appreciate though that the period of time during the 2000s were not as frequent, but, again as I said, the cards are not with us, the records are not with us. The point of other patients being regularly seen, yes they were.
- Q.** Thank you very much, Dr Austin, I think that the Committee may have some further questions for you?

Questioned by Committee

Mr Counter: Dr Austin, we have heard quite a bit about the records and the loss of the records. Do you have the records of the other 349 patients?

- A.** Yes.
- Q.** So it is just –
- A.** Well, yes, we have an Excel sheet which my wife – and that is when this was highlighted by Nigel saying, “Have you got the records?” That is when it came up that we could not find his.
- Q.** Right. I think you said – or you may have said it or it may be in the notes, I cannot remember where I came across it – but Patient A was the last patient who you saw before leaving the practice?
- A.** Yes, absolutely. I have just taken an affirmation and that was the case. We took a little time to try to persuade him to come in and get this tidied up, because it was leading up to two cycles of boxing things up, and we had been there ever since 1990, so it was a period of time which took quite a lot of clearing up.
- Q.** You have mentioned, quite rightly, the importance that you attach to the records and so on and so forth. How much space did 350 records take up?
- A.** Probably two lots of files, and it was amazing because it had been such a long time.
- Q.** Why did you not just stick them in the car?

- A.** There was no room in the car, I can assure you; the boys were even wearing their cycle helmets.
- Q.** Okay, can I just take you back? I asked you about Mr Astbury this morning and you mentioned that there were a couple of occasions that we could not date the day on which Mr Astbury saw Patient A. To your knowledge, or did he routinely, with every patient of the age of Patient A, did he perform tonometry?
- A.** Yes, he did.
- Q.** So you would have had on that record –
- A.** Absolutely –
- Q.** The track of the intraocular pressures.
- A.** Absolutely, and the contact lens treatment as well.
- Q.** So it was contact treatment?
- A.** It was.
- Q.** Right, fine, thank you.
- A.** And then he had to spend the rest of that morning without his lenses in and then he had to come back at one o'clock to have them put back in.
- Q.** Thank you very much.
- A.** Thank you.

Ms Jeyasingham: Mr King?

Mr King: Yes, just a couple of quick questions, please. What is your understanding now, of removing records from a practice?

- A.** I believe that if it was understood that if it was within your associate set-up, that that was permissible. If they were actually the existing practice's records, then they would stay in the practice.
- Q.** That was your understanding then?
- A.** I thought so, yes.
- Q.** Okay, and again if you would like just to tell me what your understanding now is of how long you actually need to keep patient records?
- A.** I understood it to be seven years.
- Q.** Thank you. No further questions.

Mr Azubike: Just one small question, on page 54 of R1, which is where your publications are, I noticed that you have listed several publications that have gone into review journals, I assume?

- A.** Yes, they have, yes.

Q. When I read them the other weekend, I realised that only three of them had been published, is that correct?

A. They have at the moment, yes.

Q. Is that correct?

A. Yes, they have gone to review and at the moment we are just making minor amendments to the others.

Q. So strictly speaking 4, 5, 6 and 7 are not publications in the true sense of the word?

A. Of the numbers down the bottom?

Q. Yes, the last four are not actually published, are they?

A. I am not sure about the Rae one, but the others are under the file – I think Sheila has now tidied up the last amendments and that has gone off for agreement. But yes, I appreciate what you are saying: these are under review or final amendments, yes.

Q. That is fine, I have no further questions, Madam.

Ms Jeyasingham: Thank you, I have no questions, so you can step down, Dr Austin, thank you.

[The witness stood down]

Mr Payne?

Mr Payne: I am not sure whether at this stage it is appropriate to hand in the character references if we don't have those? I thought that my colleague who prepared the bundle would have sent them in, but she has not.

Ms Jeyasingham: We seem to have some.

Mr Payne: I have references from Mr Botten, Ms Stott, Dr Baker and Dr Siderov.

Ms Jeyasingham: I don't think we have all of those.

Mr Payne: Those are not statements, the witness statements.

Ms Jeyasingham: No, we have witness statements from Astbury, Howard, Conway but not the ones that you have mentioned.

Mr Payne: I apologise and I wonder if those could be handed in for the Committee's consideration as well? *[Committee confers]*

Ms Jeyasingham: Could we have a look at them first? *[Documents passed to Committee]*

Mr Payne: So, Madam, in terms of the case for Mr Austin, the evidence in relation to impairment, you wish to rely upon what he said in his statement – the character references and indeed the other statements?

Ms Jeyasingham: So, these witness statements, you want us to consider them under impairment and under this stage, particularly?

Mr Payne: Yes, to the extent that they assist, some of them, I think may not assist. The latter ones, I think, may assist, but those are all evidence on Dr Austin's on part and the references to go in at this stage, as well.

Mr Whalley: I can certainly tell you from the Council's point of view that I have seen these and I am content for them to be considered at the impairment stage. The majority of them are patient testimonials so I think it is right that they are considered at this stage.

Mr Payne: Sorry, it may be that I had not handed in the testimonial; my colleague prepared the bundle and I thought that these had been sent to the Committee, so I do apologise that the Committee does not have them. They have the testimonials which are the ones referred to here, as well.

Ms Whittle-Martin: Madam, I wonder if we might just briefly break so that I can discuss it with both counsels as I have not had the opportunity to do so before.

Ms Jeyasingham: Yes, that is fine, let us have a short break.

Ms Whittle-Martin: Only five minutes.

[Hearing adjourned at 14:.44]

[Hearing resumed at 14:58]

Ms Whittle-Martin: Madam, thank you very much for the time. Both counsels and I have discussed the references and we are happy that they be admitted at this stage. In case you were wondering why that took so long we were also clarifying one other point that arose earlier on in the proceedings. I don't know whether you recall Mr Payne stating that he was admitting, on behalf of his client, deficient professional performance. I will just clarify what he meant by that.

He is not, as I understood it, meaning to bind you in any way to a formal admission, precluding you from finding one over the other – that is misconduct over deficient professional performance or the reverse. He was simply meaning to express an acceptance of an angle of the case which no doubt he will expand upon.

Mr Payne: Yes, I am grateful, my learned friend, for that. If I can endorse your Legal Adviser's summary. I was not intending to seek to bind the Committee in any way. I – and Dr Austin – accept that it is entirely for the Committee to decide whether the allegations proven fall under deficient professional performance or misconduct, that is entirely accepted. I was submitting earlier that there was clearly an acknowledgement of failings and I was submitting earlier that perhaps that might be the head under which they had fallen. I may very well submit that again, shortly, but it is entirely a matter for the Committee to decide what description it is and I accept that.

Ms Jeyasingham: Thank you very much for that clarification, Mr Payne. So, we are looking at the references, is that right?

Mr Payne: Yes, so that would be what we have and again I repeat my apologies to all members of the Committee that I do not have copies of these. A colleague of mine had prepared these and I had wrongly thought that these had been sent through so that I could at this stage have copies. So I only have the one copy. These are character references which will be left – obviously I will hand them to you and hopefully the Hearings Manager may be able to obtain copies, but in any event you can look at them while you are deliberating. Your Legal Adviser has said that this is the appropriate point to put them in. I will not read them all the way through, unless you wish me to Madam, because the Committee can consider them. There are four references: two from academic colleagues – current people who work with Dr Austin; one is a reference that you will see was dated last week and two of them are from March 2010 but they do express that they were aware of the allegations. It may well be that the wordings of the allegations have changed slightly since then, but the import of the allegations, of course, has not and the facts behind them are the same.

Also enclosed is a selection of emails and notes that were sent by former patients of Dr Austin, when he closed his practice in 2006. Again, clearly this was prior to any of these allegations coming out – they are entirely unsolicited and those are again submitted when looking at impairment as to the general competence and conduct of Dr Austin at that time. If I may hand those in to you for consideration again with my apologies that you do not have individual copies of those. [*Documents handed to the Committee*]

Madam, I am grateful, Dr Austin has just reminded me that one of his references, Dr Gary Baker, he informs me, unfortunately has cancer at present and a more up-to-date reference had been requested, but in view of his battling illness, it has not been possible to provide it.

Dr Austin: I was going forward and then I heard that he was ill, so I did not want to pursue it so I just wanted to say that and also we did not expect it to last quite so long.

Mr Payne: Thank you, Madam, so that then, in essence, is Dr Austin's case on the impairment.

Ms Jeyasingham: Thank you. Mr Whalley?

Mr Whalley: Thank you, Madam. First, I will point out some observations in relation to deficient professional performance and misconduct. As has been mentioned on at least two occasions now, these are matters for your professional judgement and, importantly, are not matters upon which the Council must discharge any burden of proof.

In terms of misconduct, that is often described as a deliberate or a reckless act or omission. I will refer to one case very briefly which the learned Legal Adviser may also mention. It is a GMC case, a General Medical Council case, *Roylance v. GMC* [2000] 1 AC 311 which was probably the clearest definition of misconduct. That was said to involve:

“Some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found in reference to the rules and standards ordinarily required to be followed by a practitioner in the particular circumstances.”

Of course I handed up the *Code of Conduct* and the *Core Competencies* earlier and I will refer to some of those which I say are relevant in this case.

Deficient professional performance is a different concept from misconduct and that suggests that the registrant lacks competence in certain areas and another General Medical Council case of *Calhaem v GMC* [2007] EWHC 2606 (Admin) provides a definition of deficient professional performance. That case said:

“It connotes a standard of performance which was unacceptably low and which has been demonstrated by reference to a fair sample of work.”

Of course that is a fact which is not present in this case, in terms of a fair sample of work. Particularly with a number of patients, often deficient professional performance would be a number of patients over a significant period of time. Of course this is one patient, but of course, it still can amount to deficient professional performance, particularly given the length of time over which Dr Austin was seeing Patient A. It certainly cannot be said to be a one off, isolate incident, in this particular case.

In relation both to misconduct and deficient professional performance, as I say, I ask to refer you to the three sets of Code standards which I handed up. As I said earlier on today, the first Code, was the one of 30 June 2005, so of course that was the end of the treatment provided to Patient A, but of course, those Codes were really incorporated into that form from what is good

practice and perhaps what is best practice. In terms of those codes, I would ask you to consider Codes 1, 5, 6 and 12, which I would say are relevant to the particular facts of this case. I will not read them out, you have the Code in front of you and certainly for the last year of the treatment in this case, they are, I say, relevant particularly to misconduct but they also do touch upon deficient professional performance. That is C3, for the record.

The other documents C4 and C5: C4 concerns competencies, contact lens practice and C5 are the core competencies. There is some overlap between the two documents. Referring first to C4, which is the competencies, there is a list of nine competencies set out there. I ask you to refer to numbers 2 and 9 which I say are relevant in this case.

C5 is a longer document and it has more detailed competencies in there and I would ask you to refer to competencies 2 and 5, which set out within each of those a number of sub-competencies. Again I say that they are relevant for your considerations on deficient professional performance and misconduct. You will, of course, be assisted by the professional practitioner members on the Committee who will be able to give their professional view on those matters.

If you find some or all of the admitted and proven facts do amount to either misconduct or deficient professional performance, then the next stage is to consider whether Dr Austin's fitness to practise is impaired. As you will be aware that is a present day test and as well as looking forward as to the future of Dr Austin's practice, you will, of course, in this case – you have to – look back. The conduct, as alleged, occurred, as we know from 1991 to 2006, so by the very reason of those dates, you will have to look at the conduct during that time.

You should consider if the misconduct or deficient professional performance found is remediable and indeed, what steps – if any – has Dr Austin taken to remedy that. It is a slightly different case from the many that you may hear, because, of course, Dr Austin is no longer in full time clinical practice, he has now turned to academia so you, of course, have to consider whether on his evidence and what is provided he has demonstrated any insight and steps to remedy the failings which indeed he has more or less admitted.

As well as considering those matters, you should also consider the public interest matters, namely the need to maintain public confidence in both this process and also the profession, and declaring and maintaining of proper standards of conduct and behaviour. It is the Council's case that Dr Austin's fitness to practise is impaired. Allegations 1, 3, 4 and 5, which are all allegations save for the records, the matter of the notes being lost, occurred over a significant period of time, which I submit is an aggravating feature of this case. Dr Austin, of course, in evidence, said that he did not see Patient A for as long during the period 2000 to 2006, but certainly a significant period of time, so, as I said earlier, it cannot be said to be a one-off, isolated incident,

albeit that it is one patient. Essentially the conduct was repeated on many occasions.

In terms of the allegation concerning the misplaced lost patient records, that is also a serious allegation. Of course, Dr Austin was very candid and accepted that in his evidence and I am sure that there was no intention to lose these records deliberately, but of course the onus is on Dr Austin to make sure that those records are kept safely. That is for two reasons: first, to protect patient confidentiality – which of course, is a very important point – and secondly for future treatment so that the next practitioner and the practitioner after that is able to access the history and all of the patient records. For those two reasons, I submit that that allegation is also serious. So, for those points, it is the Council's case that Dr Austin's fitness to practise is presently impaired.

Those are my submissions unless I can assist any members of the Committee further.

Ms Jeyasingham: Thank you, Mr Payne?

Mr Payne: Thank you, Madam. On behalf of Dr Austin, the contrary is submitted: that his fitness to practise is not impaired, at all.

First perhaps to deal with the question of misconduct or deficient professional performance, yet again I repeat what I said earlier – clearly a decision for the Council. I endorse what my friend has said about *Roylance* and *Calhaem* and the guidance given there and of course we will hear from your learned Legal Adviser in due course.

Again, this came up in the case that I handed to your Legal Adviser earlier and she has a copy. That was a case before Mr Justice Ouseley in January of this year, *The Queen on the Application of Vali v General Optical Council* [2011] EWHC 310 (Admin), so I refer to a decision of this body. Mr Justice Ouseley addressed the question of misconduct and deficient professional performance in looking at the decision of another constitution of this Committee and he indicated – your learned friend has the decision – that the two were distinct matters. Again, he referred to the *Calhaem* judgement upon this and the five principles there, Mr Justice Jackson had referred to upon the question of what degree the nature or gravity of an act constitutes misconduct. He quoted these five principles:

“The mere negligence does not constitute misconduct” – the meaning of and obviously the medical act – and depending on the circumstances, negligent acts or omissions which are particularly serious may amount to misconduct.”

Second principle:

“A single negligent act or omission is less likely to cross the threshold of misconduct than multiple acts or omissions, although depending on the circumstances, a single negligent act could do that.”

We are not talking about a single act here.

Third principle:

“Deficient professional performance is conceptually separate, both from negligence and from misconduct.”

And as my friend has said the decision said:

“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 doctor’s work.”

Fourth principle:

“A single instance of negligent treatment unless very serious indeed would be unlikely to constitute deficient professional performance.”

And fifth principle:

“It is neither necessary or appropriate to extend the interpretation of deficient professional performance in order to encompass matters which constitute misconduct.”

Again, the judgments stress that it is a matter for you. It is submitted that it may be that the Committee would consider these err more on the side of deficient professional misconduct. There was not, in any of these matters, it is submitted, a deliberate act, akin, for example to a dishonesty or a theft where there may be one matter which triggers registrants appearing before disciplinary committees. It was not anything of that nature at all: it was clearly an oversight, as we have heard in the evidence, a continuing oversight and failure and omission to have forwarded, in terms of the allegations, to have referred the gentleman for an eye test to ensure that the prescriptions were there and so on and so forth. To that extent, it is a continuing course of conduct. I accept that the part that I have just read to you refers to a fair sample of the doctor’s work: to that extent it was a continuing omission and one – if you like – that certainly on the procedural side was not followed up at all. I do not demean the omission by use of the word ‘procedural’ because Dr Austin has admitted the severe consequences that can follow from that.

In terms of suggesting that the Committee may wish to look at in those terms, it is submitted that that may well be an unacceptably low standard of work over that period of time, not to have referred and ensured that prescriptions and so forth were available. In that sense, it would be submitted that the

Committee would be entitled to find that that was an unacceptably low standard over a period of time. I will say no more on that, because that is a matter for you.

In terms now of the fitness to practise going forward, I find it helpful on these occasions to look at the guidance produced by the GOC itself. It is, of course, only guidance, but it does helpfully summarise the matters to which advocates as well as members of the Committee should have regard. In terms of the mitigation and so forth, in terms of different factors, Madam, it is submitted that it is helpful to look at certain of the matters prepared there.

Of course, as my friend said and your Legal Adviser will doubtless remind us, the leading case remains *Azzam v GMC* [2008] EWHC 2711 (Admin) which is cited in the GOC guidance and of course the guidance of Mr Justice McCombe, who said, in 2008:

“It must behove the Fitness to Practise Panel to consider facts material to the practitioner’s fitness to practise looking forward and for that purpose to take into account evidence as to his present skills, or lack of them, and any steps taken since the conduct criticised, to remedy any defects in skill.”

Again, it is worth looking at that, and again without in any way minimising the wrongdoing admitted by Dr Austin and the findings against him, there is an emphasis certainly in that quotation upon skill and so forth in clinical practice and that is very often the case here. The allegations against Dr Austin are not of that nature, with regard to his clinical practice, they come from the failure to follow the obligations that underpin the clinical practice and as we have heard and submitted that is a fact which the Committee ought to bear in mind.

In terms of the mitigating factors, again the GOC’s own guidance looks at circumstances leading up to the incidents in question as well as evidence about the Registrant’s previous good character and history. With regard to the previous good character and history, again, it is prayed in aid of Dr Austin that they are the submissions of the testimonials from his former patients which you will be able to have a look at in your deliberations. It is submitted that these will demonstrate that there were many patients who were very pleased with the care given to them over many years by Dr Austin. We have heard in the evidence from Dr Austin that from his case studies at the time that he concluded his clinical practice, there were no concerns expressed at all by any other patient. We have heard that that was the case in his practice and we have also heard from Dr Austin that since he retired from clinical practice in Perfect Vision and went into academia that likewise there have not been any complaints about his performance or anything of that nature.

Again, the Committee would be asked to take that into account and to place the admitted and the found failings of Dr Austin in this case into the context, again outlined in his statement, of an otherwise unblemished career whereby

in his clinical practice and indeed in his academic practice, the overall picture is an overwhelmingly positive one and one I would suggest of an individual who is fit to practise.

In terms of mitigation, the Committee may well also take into account any actions taken to apologise and a demonstration of insight. It is submitted to this Committee, we have heard that Dr Austin did take steps in an email via the GOC to apologise to Patient A. His statement – again, if the Committee re-reads it when deliberating – makes it clear that, yet again, he apologises to Patient A. He understands the distress to this individual patient. It is submitted that he has demonstrated to you that he understands clearly the consequences of his failings in this case and it is submitted to that extent that the Committee can find that there has been a demonstration of insight on the part of Dr Austin as to the failings in this case. Again, that goes, of course, as to whether there is likely to be a repeat of these matters in the future. Again, Dr Austin – although in academia now – has a number of positions. The statement sets them all out. He is an external examiner for other institutions. He supervises his own students. He works in research as well, all of which, it is submitted are for the benefit of the public and the population as a whole and for the ongoing development of optometry and optical science.

Dr Austin has assured this Committee that the likelihood of any of these omissions being repeated is zero: it simply will not happen again. He, of course, not surprisingly, indicates that this whole process has taken its toll upon him and proved incredibly stressful to him. That in itself, of course, has been since his allegation, something of a daily reminder as to the conduct which led to these proceedings and that in itself is a powerful factor which it is submitted the Committee can reply upon in showing that Dr Austin has learned from his past failings. However, as we have heard, he actually has responsibility for teaching the future generations of opticians and so forth who are coming through his university course. The Committee will see for themselves, in particular, the clinical sheet that as we heard Dr Austin had a major part in devising and teaching current students. That, of course, stresses – as we have heard from him orally and in his statement – the importance of regular eyesight prescriptions and so forth. Not only does he teach these matters but he examines on them as well.

It is submitted that there can be no clearer ongoing demonstration of Dr Austin's awareness and it is submitted that there would be no reason for the Committee not to give that the weight that it deserves in considering the future fitness to practise. He is aware, on practically a daily basis, of these issues, and he is actually reminding and teaching others about them.

Again, looking at the sort of factors that the GOC's guidance suggests are mitigating or aggravating: clearly the potential impact on a victim of not being tested or so forth could be very grave. We have heard Dr Austin say that himself; he fully accepts that and fully accepts, therefore, the need to ensure that mistakes like this do not happen again. He fully regrets what happened

ultimately to Patient A in this case, although of course it has not been any part of the evidence that what subsequently happened to Patient A was because of the failings admitted by Dr Austin. That has not been alleged at any stage and I am sure that that will not be part of the Committee's deliberations. Nevertheless, he fully recognises the potential for harm from those failings. There was no abuse of trust and so forth. We have heard that, although this was a repeated failing, Dr Austin, it is submitted, has co-operated fully with the Committee. It is not a criminal court, but by analogy with the approaches taken, I ask full credit be given to Dr Austin for his co-operation and his admitting of those failings. He is not sought to prevaricate on those matters at all. Again, the admission of wrongdoing, it is submitted, is a powerful factor, upon which the Committee can rely on in being satisfied that those won't happen again.

There are, of course, the testimonials and one can consider – the Committee is entitled to consider those – in the course of practice and place such weight upon them as the Committee sees fit.

In terms of the records and what my friend has said about the way in which the Codes of Conduct has been breached by Dr Austin, it is admitted – and the Committee has heard those admissions – and therefore it is accepted that the Commission may very well be entitled to find that the Code of Conduct *extant* at the time was not kept.

In terms of the lost records, as we have heard, although there was a third party involved, Dr Austin accepts full responsibility for the loss of those records. He accepts the importance of that and the potential consequences of that for an individual with a history not being available. It may well be, of course, that the loss of those records has hampered Dr Austin in preparing for these proceedings. That is as may be. That may be a result from that.

In terms of going forward, it is submitted that the loss of those records should be placed in the context of Dr Austin finishing his practice – not only that, but also moving house. He referred to other stressful personal factors that he did not wish to mention, but the Committee would be invited to accept – because there is no reason to consider that Dr Austin was not being truthful – that he had a number of pressures at that time. Self-evidently, moving house, the life changes of moving house, as well as moving career, in addition to any other personal pressures, would have been in particular at that time.

Again, going forward, we have heard that Dr Austin is an academic and therefore he is not in the position where he is responsible for keeping the individual patient records of an individual in that fashion. So it is most unlikely that there would be any repeat of those matters, but again, should Dr Austin be deemed fit to practise and at some stage return to practise in the future, it is accepted that the Committee may have concerns as to how records may be kept. Again I would really repeat or refer to what I said earlier, in the sense that this has been very much a question of lessons learned by Dr Austin and

the assurances that he has given the Committee that these things certainly would not happen again.

Certainly in relation to that one, I would ask the Committee to put that into the proper location: it is different, it is submitted, from the continuing failure, on Dr Austin's part to obtain prescriptions on the eye sights, this came about from a practical set of consequences for which Dr Austin has properly taken responsibility but it is unlikely that that would be a future risk. That in itself, it is submitted, should not influence the Committee in terms of fitness to practise in the future.

Finally, of course, looking forward, we have heard from Dr Austin that since this happened he has continued to make great strides in academia. As I mentioned earlier, he has studied for and completed his PhD. He has been developing courses and as you have seen and I invite you to reconsider, his statement and the testimonials, he has been involved in projects for which funding has had to be bid and the projects have then had to be delivered, and they have been evaluated to a high standard. These are all matters which clearly benefit the optical industry and therefore patients going forward. Of course the emphasis on the panel would need to be the protection of the public and the panel will clearly need to be mindful of whether or not, going forward, there is a risk to members of the public with Dr Austin continuing to practise.

Again, it has been some time since the allegations first were made and brought to the attention, but also the timeframe of them – between 1991 and July 2006, which was some five years ago, has indicated that there haven't been any concerns at all, in any regard, against Dr Austin during that period of time.

Of course, although academia remains his employment at the moment, as we have heard from him there is a clinical element to that, in supervising students and there is clinical contact. He has not had any concerns expressed about his work in that context.

Madam, can I refer you again – your learned Legal Adviser has the same case to which I referred earlier when talking about the misconduct and deficient professional performance issues, that of *Vali*. Madam, in this case, Mr Justice Ouseley in the High Court – the Administrative division – looking at this, he himself made the decision upon the GOC's Committee and made certain observations with which I will not trouble the Committee at this stage. But Madam, rather than remitting the matter to the Committee for a finding on the fitness to practise, he took over that exercise himself. Madam, I am looking at paragraph 51 here and he said this and I will read this in full:

“I conclude that the finding of impairment would not, as at 2010, have been justified.”

By way of background, Madam, the case that was being looked at there, I think involved an allegation from 2005. Yes, it was a 2005 allegation, so it is almost a comparable timeframe to that with which we are dealing here.

So he says:

“I conclude that a finding of impairment would not, as at 2010, have been justified”

– because the GOC was looking at this in 2010 and as indicated, Mr Justice Ouseley took this decision in January of this year. He said:

“This was – albeit serious – a one-off oversight. The error has not been repeated on the evidence, nor have any like errors been repeated. The level and number of testimonials suggests that the error has not been repeated in circumstances falling short of those which might give rise to a complaint. She has not been dismissed for failings and previous employees and employers have supported her. She has progressed in her supervisory roles and in her teaching roles. In my view, it is hard to conceive that somebody who is a continued risk to public safety or to public confidence in the competence and standing of the profession would have progressed as she has done. It is not necessary, therefore, for me to consider sanction.”

He indicated that there was no impairment. Of course, each case turns entirely on its merits, but I highlight that for you, because there are, on the face of it, clear parallels in principle with Dr Austin’s case in that he has continued in his career. He has continued, if I can describe it this way, in an upward curve in terms of his achievements academically in teaching and indeed in projects and in industry. He has not had any concerns expressed to him whatsoever, at all, by anyone, as indicated and he has continued both in the teaching role with that clinical output. So, again, I would submit and invite you to consider carefully the way in which Mr Justice Ouseley dealt with it on the similar evidence and again submit that sort of approach would indicate, looking forward, that there is no evidence that Dr Austin’s fitness to practise is impaired.

Again, looking forward therefore and summarising all of those matters, as we have heard Patient A was a demanding and unusual individual; certainly his treatment was unusual; he was a forceful character and Dr Austin accepts entirely that it was wrong for his decision-making and so forth to have been – if you like – subsumed to the force of an individual’s character. He has indicated to this Committee that he certainly would not do that again if he was in a comparable position. Clearly there have been no complaints about this Registrant’s work in any capacity, prior to this series of incidents or post this series of incidents. It is submitted that it is of significance that while this one individual was not treated properly, as we have heard, in certain respects, that the rest of Dr Austin’s practice, it can be inferred, certainly were and there are

testimonials to that effect. He has indicated his insight and his remorse to matters. He is actively involved in training those potential entrants to the profession warning against precisely the sort of failings to which he has admitted, which again should give the Committee – hopefully – the reassurance that these matters would not be repeated.

So again, urging the Committee to look forward and take into account the overall picture, it is submitted that Dr Austin's fitness to practise going forward is not impaired.

Those would be my submissions, Madam, to members of the Committee, unless there are any other specific points which you would wish me to address.

Ms Jeyasingham: Thank you, Mr Payne

I will now invite the Committee's Legal Adviser to advise the Committee.

Ms Whittle-Martin: Madam, I can either do that now and I am ready to do so, or I can do so tomorrow, if you would rather I do it before you start your deliberation. I genuinely mean that I am ready to go ahead now if you would prefer me to do so.

Ms Jeyasingham: I think we will go ahead with your advice and then we can go into our deliberations and so on and reconvene tomorrow.

Ms Whittle-Martin: Madam, as you have heard it is now for you to consider whether the practitioner's fitness to practise is impaired by reason of his misconduct and/or his deficient professional performance. That is, as you have heard, a two-stage process, in that you must first ask whether, in your judgement, the matters that were admitted, and the matter that you found proved at the fact-finding stage amounts to misconduct and/or deficient professional performance. If you find that there has been misconduct and/or deficient professional performance, then we move on to ask whether, in your judgement, the Registrant's fitness to practise is impaired as a result of one or both of those.

Looking first at the definition of misconduct, the first point is that there is no definition of misconduct in the relevant legislation, so one really has to look to case law to see what the meaning of it is. Also, one has to bear in mind, throughout, that whether or not the alleged conduct amounts to misconduct is a matter for your own professional judgement, so the concepts of burden and standard of proof must now be put to one side.

There has been mention of the case *Roylance* and might I remind you of what was said there by Lord Clyde in relation to misconduct. He said this:

“The Professional Conduct Committee are well placed in the light of their own experience, whether lay or professional, to decide where precisely the line falls to be drawn in the circumstances of particular cases.

Misconduct is a word of general effect involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a medical practitioner in the particular circumstances. This misconduct is qualified, however, in two respects. First, it is qualified by the word ‘professional’, which links the misconduct to the professional medicine. Secondly, the misconduct is qualified by the word ‘serious’. It is not any professional misconduct which will qualify but professional misconduct must be ‘serious’.”

In fact, that case took place before the relevant Act which we must now follow. That problem, however, was solved by a case called *Calhaem*, by which time the relevant Act was in place. That case clarified this: the word ‘misconduct’ does not mean any breach of duty owed by a doctor to his patient, but it connotes a ‘serious’ breach, which indicates that the doctor’s fitness to practise is impaired.

So although the previous Act spoke of serious professional misconduct, the meaning remains the same. So the authorities to which you must now look are continuing, so it is ‘serious’ professional misconduct, not *any* misconduct.

His Lordship in that case then considered the relationship between negligence and misconduct which has also been touched upon in this here. He said two things, first he said:

“Mere negligence does not constitute misconduct, nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to misconduct.”

Secondly:

“A single negligent act or omission is less likely to cross the threshold of misconduct than multiple acts or omissions, nevertheless, and depending on the circumstances, a single negligent act or omission, if particularly grave, could be characterised as misconduct.”

Moving on then, to professional performance, again there is no statutory definition but in the same case to which I have just been referring, the case of *Calhaem*, Mr Justice Jackson derived from previous authorities, a number of principles and three of them are these:

First,

“Deficient professional performance is conceptually separate both 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 doctor’s work.”

Secondly,

“a single incidence of negligent treatment – unless very serious indeed – would be unlikely to constitute deficient professional performance.

Thirdly,

“it is neither necessary nor appropriate to extend the interpretation of deficient professional performance in order to encompass matters which constitute misconduct.”

You have been referred by the defence to the case of *Vali*. In that case, the facts – which included an allegation that the registrant had failed to make a referral and was described as a “serious, one-off oversight case” by Mr Justice Ouseley, Mr Justice Ouseley said this:

“There are no additional factors referred to by the Committee in its conclusion on deficient performance from those which justified its conclusions on serious misconduct.”

He then referred to the case of *Calhaem* to which I have just taken you and he said this:

“I have no hesitation at all about the fifth of Mr Justice Jackson’s principles – ”

– that is the principle which read as follows:

“It is neither necessary nor appropriate to extend the interpretation of ‘deficient professional performance’ in order to encompass matters which constitute ‘misconduct’.”

Mr Justice Jackson said:

“I have no hesitation at all about the fifth of his principles which cautions, entirely appropriately, against extending deficient professional performance to encompass misconduct.”

I would add, vice versa: it is important that deficient professional performance should not be contorted so that it is a mere synonym for misconduct in practice. The essence of deficient professional performance is more in contrast to, then co-terminus with, misconduct.

It is intended at least to be different in that one would often – if not normally – expect to find a pattern of conduct underlying the allegation of deficient professional performance.

I do not intend to lay down any particular principle in those observations, but to draw attention to the need for care over charging exactly the same conduct under both heads. Of course, there may be different facts which justify the same because viewed from different perspectives being charged under both heads, but that is not this case. There may be also circumstances in which an allegation of misconduct may be made but be insufficiently strong in the end to warrant a finding but the underlying facts should nonetheless fall out of picture for the purposes of deficient professional performance charge.

Bearing in mind those observations, I conclude in this case, that the Committee was wrong to find that this was a deficient professional performance, because it had found that it was misconduct. It is necessary to keep – so far as possible – some distinction between the two. I accept that what happened here could be found to deficient professional performance, but it would – in those circumstances – have been wrong simply to have found a misconduct charged proved.”

Moving on then to the case that you have been taken to, to the case of *Meadow v GMC* [2006] EWHC 146 (Admin) where the Court of Appeal made it clear that the deficiency of the professional performance must again be serious in order for it to amount to impairment.

Lastly, before moving on to impairment, you have been provided by the defence with a selection of testimonials and you can properly take account of that evidence relating to such matters as the Registrant’s competence or reputation in relation to the subject matter of the allegation and the Registrant’s actions since events giving rise to the allegation and the existence or absence of similar events. I should say that if there is more general character evidence, which has no direct bearing on the finding to be made by the panel at this stage, such as the Registrant’s standing in the community or reputation more generally, then perhaps reserve those aspects of those testimonials to the sanction stage.

In that regard, Mr Payne has referred you to the Fitness to Practise Panel’s Hearings Guidance and so may I remind you of the section of that guidance that was read to you, which read as follows:

“Letters of testimonial which attest to the steps taken by the Registrant to remedy the conduct which led to the hearing – for example from professional colleagues – and evidence of the Registrant’s current fitness to practise will be relevant at the point when the Committee is considering the issue of impairment.”

As Mr Justice McCombe said in the case of *Azzam*:

“It must behove an FTP panel to consider facts material to the practitioner’s fitness to practise looking forward and for that Panel to take into account evidence as to his present skills or lack of them and any steps taken since the conduct criticised to remedy any defects in skill. I accept that some elements of reputation and character may well be matters of pure mitigation, not to be taken into account at the impairment stage, however the line is a fine one and it is clear to me that evidence of a practitioner’s overall ability is relevant to the question of fitness to practise.”

So moving on to the question of impairment, Madam, again I am afraid that there is no definition of impairment: it is a finding based upon your collective judgement and bearing in mind your duty to maintain and uphold standards in the public interest. The *Shipman Report* helpfully identified the current features of cases in which impairment of fitness to practise had been found to exist. Lady Justice Smith said this:

“I think that it would be helpful in the resolution of the problems that I am about to outline, if I analyse the reasons why a decision maker might conclude that a doctor is unfit to practise, or that his or her fitness to practise is impaired. In the examples I have discussed, four reasons for unfitness to have occurred and they were first: that the doctor presented a risk to patients; secondly that the doctor had brought the profession into disrepute; thirdly that the doctor had breached one of the fundamental tenets of the profession; and, fourthly that the doctor’s integrity could not be relied upon.”

She continued:

“Another potential problem arises with the time when fitness to practise is measured or assessed. The 1983 Act permits the Fitness to Practise panel to take action on registration if it finds that the doctor’s fitness to practise is impaired.”

That implies that the impairment must be present at the time of the hearing. So if a doctor has committed a serious act of misconduct a year ago, does that indicate that his or her fitness to practise is currently impaired?

She said that she understood that the GMC in that case had been advised that although the 1983 Act refers to finding that a doctor’s fitness to practise is impaired, a present impairment of fitness to practise can be founded on past matters. She concluded:

“That seems sensible and that a doctor’s current fitness must be gauged partly by his past conduct but also judged by reference to how he is likely to behave or perform in the future.”

So, in a misconduct or deficient performance case, the task of the panel is to determine whether the fitness to practise is impaired by reason of misconduct or deficient performance. It may well be – especially in circumstances in which the practitioner does acknowledge his deficiencies and take prompt and sufficient steps to remedy them – that there will be cases in which a practitioner is no longer any less fit to practise than colleagues with an unblemished record.

In the words of Mr Justice Silber in *Cohen v GMC* [2008] All ER 307:

“Any approach to the issue of whether a doctor’s fitness to practise should be regarded as ‘impaired’ must take account of *‘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 of the public in their doctors and that public interest includes, amongst other things, the protection of patients and maintenance of public confidence in the profession.’* In my view, at stage 2, when the fitness to practise is being considered, the task of the Panel is to take account of the misconduct of the practitioner and then to consider it in the light of all of the other relevant factors known to them in answering whether by reason of the doctor’s misconduct, his or her fitness to practise is impaired. It must not be forgotten that a finding in respect of fitness to practise determines whether sanctions can be imposed.

I must stress that the fact that stage 2 is separate from stage 1 shows that it was not intended that every case of misconduct found at stage 1 must automatically mean that a practitioner’s fitness to practise is impaired.

There must always be situations in which a panel can properly conclude that the act of misconduct was an isolated error on the part of the medical practitioner and that the chance of it being repeated in the future is so remote that his or her fitness to practise has not been impaired. Indeed the Rules have been drafted on the basis that once the panel has found misconduct, it has to consider as a separate and discrete exercise whether the practitioner’s fitness to practise has been impaired. Indeed Section 35D(3) of the Act states that where the panel finds that the practitioner’s fitness to practise is not impaired, *‘they may nevertheless give him a warning regarding his future conduct or performance’.*”

I should also, I feel, remind you of the case of *Cheatle v GMC* [2009] EWHC 645 (Admin) in which Mr Justice Cranston said this:

“In my judgement the context of the doctor’s behaviour must be examined. In circumstances where there is misconduct at a particular

time, the issue becomes whether that misconduct, in the context of the doctor's behaviour both before the misconduct and at the present time, is such as to mean that his or her fitness to practise is impaired. The doctor's misconduct at a particular time may be so egregious that, looking forward, a panel is persuaded that the doctor is simply not fit to practise medicine without restrictions or maybe at all. On the other hand, the doctor's misconduct may be such that, seen within the context of an otherwise unblemished record, a Fitness to Practise panel could conclude that, looking forward, his or her fitness to practise is not impaired despite the misconduct."

Finally, may I end with the remarks of Mr Justice Silber in the case of *Cohen*, where he expressed the public interest principle which you must bear in mind throughout these proceedings, in these terms:

"Any approach to the issue of whether a doctor's fitness to practise should be regarded as 'impaired', must take account '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 and that public interest includes, amongst other things, the protection of patients and the maintenance of public confidence in the profession'."

That, you may be pleased to hear, concludes my advice and if you would wish for it to be printed out, I am very happy to do that, as I appreciate that it is difficult to follow without having it in front of you, but because things have moved along quickly today, I did not have time to print it out.

Ms Jeyasingham: That is fine, thank you, Ms Whittle-Martin. Are there any comments on the legal advice?

Mr Whalley: No, thank you.

Ms Jeyasingham: In which case, I am going to clear the room and also adjourn the hearing for today. We will be available from 9.30 tomorrow.

[Hearing adjourned at 15:56]

Day Two
Tuesday, 4 October 2011

[Hearing resumed at 11:52]

Dr Jeyasingham: While considering the evidence, the Committee has come across a particular issue that we wanted to raise with you, so I am going to ask our Legal Adviser to ask, I think, particularly Mr Whalley, about a piece of evidence that we are considering.

Ms Whittle-Martin: It is a very straightforward point and we are sorry to drag you back and I think I had better take responsibility for it.

It is simply that we have been given three exhibits, C3, C4 and C5 all of which deal with *Code of Conduct* and *Competencies*. We have no difficulty with C3 because it is dated June 2005 and no difficulty with C5 because it is dated November 2004; the difficulty that the panel has currently in relation to C4 is that it has no date on it and we wondered whether you would be able to provide us with an indication of its relevance, because of course if in fact it was not in place at the time then it is irrelevant.

Mr Whalley: Forgive me, can I just check that C4 is the single document?

Ms Whittle-Martin: C4 is the single document entitled *Competencies, Contact Lens Practice*.

Mr Whalley: My understanding that is also dated 2004, I believe November, the same date as the other core competencies and they were introduced at the same time, I am not sure why they are a separate document.

Ms Whittle-Martin: Would you like to just check that, please?

Mr Whalley: Absolutely, certainly.

[Hearing adjourned at 11:53]

[Hearing reconvened at 12:07]

Ms Jeyasingham: Thank you, Mr Whalley?

Mr Whalley: Madam, I have spoken with the education department who introduced and indeed maintain the *Codes of Conduct and Competencies*. What they have informed me is that they were introduced at the same time as the larger of the documents, namely 17 November 2004. They are not dated and unfortunately I cannot provide you with a dated copy but the employee with whom I spoke was very clear that they were introduced at the same time. They were the first time that any formal Codes were introduced in 2004,

before that time it was an educational curriculum. They were formalised in 2004 and they have been updated since. This document was updated in 2008, but in fact it was not updated, there was no change – so the one which you will see on the website is 2008 but it is identical to this, but it was actually 2004 when it first came into law.

Ms Whittle-Martin: That is very helpful, are you happy with that, Madam?

[Committee confers and agrees]

Ms Whittle-Martin: Thank you.

Mr Whalley: Thank you, Madam.

Ms Jeyasingham: I was going to announce that we were probably going to take lunch as well, so if you could be available from 13.30, thank you.

[Hearing adjourned at 12:08]

[Hearing reconvened at 15:23]

Ms Jeyasingham: I am going to read out the findings in relation to deficient professional performance and/or misconduct.

Findings in relation 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 three months at a time.

The Committee first considered whether there had been deficient professional performance. It had regard to the case of *Calhaem*, 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 three 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*, 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 three 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.

At this point, Dr Austin, can you stand?

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 all of which

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.

Thank you, you may stand down, Dr Austin.

Unless there are any other issues, I declare the hearing closed.

[Hearing concluded at 15:33]