

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

GENERAL OPTICAL COUNCIL

F(11)07

AND

KIN WENG FOO (01-22309)

**DETERMINATION OF THE INQUIRY
7-9 NOVEMBER 2011 AND 11 JANUARY 2012**

On 7-9 November 2011 and 11 January 2012, the Fitness to Practise Committee of the General Optical Council met to consider allegations against Kin Weng Foo.

ALLEGATION

The Council alleges that, in relation to you, Kin Weng Foo, a registered optometrist:

1. On 20 November 2009 you conducted an eye examination of Patient A.
2. During your internal eye examination of Patient A you found a pigmented lesion in the left eye.
3. You failed to provide adequate care to Patient A in that:
 - (a) you failed to undertake and/or arrange for appropriate tests and/or investigations to be undertaken urgently in relation to the said lesion, namely
 - (i) an Amsler Chart assessment of Patient A's central field of vision; and/or
 - (ii) an examination with pupil dilation using binocular indirect ophthalmoscopy;

and/or

- (b) you failed to refer Patient A urgently to a suitably qualified person in relation to the lesion;

and/or

(c) you failed to inform Patient A fully of your findings and/or that he would need to undergo further tests and/or investigations as a matter of urgency and/or that he should be referred to a suitably qualified person as a matter of urgency.

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

- (a) misconduct
- (b) deficient professional performance

DETERMINATION

Findings in relation to the particulars of the allegation

The registrant admitted particulars 1 and 2 of the allegation and this followed that the Committee found them proved.

Findings in relation to the facts

The Committee carefully considered all the evidence it has received, both oral and documentary as well as the submissions of Miss Curtis, for the GOC and Mr McGee, for Mr Foo.

It reminded itself that the burden of proving its facts is on the GOC alone and that the standard of proof is the ordinary civil standard, namely the balance of probabilities. The Committee has accepted the advice of the Legal Adviser. The case concerns a single consultation that Mr Foo had with Patient A at the Tesco's Optician in Shoreham by Sea, West Sussex on 20 November 2009.

The agreed facts are that Mr Foo, a locum optometrist, conducted an eye examination of Patient A on 20 November 2009 and that during the internal eye examination he found a pigmented lesion in the left eye. The essence of the GOC's case is that Mr Foo, having noticed this lesion failed to provide adequate care for Patient A in that he did not undertake appropriate testing and did not urgently refer Patient A when he ought to have done. It is also alleged that he did not fully inform Patient A of his findings and of the potential seriousness of them.

Four days after the consultation, Patient A attended Boots Opticians in Brighton. At the second consultation the optometrist noted a pigmented lesion and immediately referred him to the Hospital Eye Services where a malignant melanoma of the choroid was diagnosed and which was subsequently treated.

There have been specific factual disputes between Patient A and Mr Foo, where their recollections of events are completely different. In particular whether, Patient A reported a 'green tinge' to Mr Foo and whether Mr Foo told Patient A about the lesion and what advice he gave him.

It has therefore been necessary for the Committee to make an assessment of the credibility and reliability of the accounts of Patient A and Mr Foo.

While the Committee accepts that both Patient A and Mr Foo were honestly doing their best to assist the Committee, it is satisfied that neither of them had perfect recollection of

the consultation, that at times both were victims of faulty remembering, and to some extent, post event rationalisation.

In respect of the discrete disputes of facts, the Committee is not persuaded, on the balance of probabilities, that Patient A did mention the 'green tinge' to Mr Foo. It notes that Mr Foo did record detailed information as to the history from Patient A and that 'green tinge' was not referred to by Patient A in his initial written complaint. Further, the Tesco receptionist who first entered Patient A's reason for visit on the card, did not record "green tinge".

However, the Committee does accept that Patient A was, as he stated a mild hypochondriac and that had Mr Foo fully informed him of the finding of the lesion, he would have immediately gone to his G.P., with whom he had a close and longstanding relationship or to hospital. The Committee thinks it more likely than not that Mr Foo concluded that the lesion was very likely to be benign and, possibly, from a desire not to worry Patient A, he did not emphasise its potential seriousness. The Committee thinks at most he only referred to pigmentation in passing and did not use the word benign or otherwise explain to the need for urgent further testing.

Given the Committee's findings on these factual disputes, it now applies these to the disputed particulars.

Particular 3(a)

The Council's case as drafted, is that Mr Foo failed to undertake and or arrange for appropriate tests or investigations to be undertaken urgently in relation to the lesion "namely i. Amsler Chart Assessment of Patient A's central field of vision and/or ii. an examination with pupil dilation using binocular indirect ophthalmoscopy." Mr Foo did not perform an Amsler Chart assessment or examine Patient A with pupil dilation using indirect ophthalmoscopy. The Council's case, on the wording of this charge is that Mr Foo had a duty in the presenting circumstances to use these specific two methods of testing.

Mr Foo used direct ophthalmoscopy without dilating Patient A's pupils. He contended that he used a red-free filter – which can assist in distinguishing between benign naevi and melanomas and, further that he subsequently applied the mnemonic TFSOM to assisting in his assessment of the lesion. The Committee finds it significant that there is no record of use of the red-free filter or TFSOM, and thinks it more likely than not that Mr Foo's recollection is faulty.

In the Committee's judgment, when faced with what he saw, using undilated direct ophthalmoscopy, the critical action that Mr. Foo ought to have done was to dilate the pupil and then perform binocular indirect ophthalmoscopy. This would have afforded him a significantly wider field of view and more information upon which to make an informed decision.

The Committee addresses the allegation 3(a)(ii) first.

Pupil dilation/Indirect ophthalmoscopy

The Committee notes Mr Foo's record that Patient A's undilated left pupil measured only 1.5mm. Using direct ophthalmoscopy with an undilated pupil Mr Foo did manage to note the lesion and provide an estimate of its measurement. However the Committee accepts the expert evidence of Dr Harper to the effect that his ability to make a proper and

efficient assessment of the size and nature of this lesion was significantly restricted by this choice of assessment. The Committee finds, that confronted with this presentation, its potential seriousness and the very limited ability to assess it properly, using undilated direct ophthalmoscopy, that Mr Foo should have utilised indirect ophthalmoscopy with pupil dilation. Accordingly part 3(a)(ii) is proved.

The Amsler Chart

This is a simple, quick test that was available to Mr Foo. It would have been a useful adjunct that would have raised the index of suspicion. Mr Foo did not choose to do this test, but chose to recommend automated threshold visual field testing at a future date. The Committee is not satisfied that Mr Foo made appropriate arrangements for further testing in that they were not sufficiently specific and urgent.

However, the Committee is not persuaded in the circumstances that there was an obligation duty upon Mr Foo to utilise this method of assessment as opposed to alternative visual field tests. It noted the expert evidence of both Dr Harper for the GOC and Mr Taylor for Mr Foo and their opinion that while this is a useful assessment tool, it is in effect not mandated in such circumstances. Accordingly charge 3(a)(i) is not proved.

Particular 3(b)

The Committee found that Mr Foo did not utilise pupil dilation and indirect ophthalmoscopy as he ought to have done. The consequence of this was that, the level of information as to the potential of the lesion that he had was limited. In such circumstances he was in error to assume that it was benign and ought to have arranged for an urgent referral to a suitably qualified person. Given the Committee's conclusion that the arrangements for the threshold visual field testing that Mr Foo made were not sufficiently specific and urgent, it follows that this did not discharge the responsibility to refer. Accordingly 3(b) is proved.

Particular 3(c)

Given the Committee's finding set out above, particular 3(c) is proved on the basis that Mr Foo did not fully inform Patient A of his findings in that he glossed over the potential seriousness of the lesion; did not make it clear that he needed further investigations as a matter of urgency and did not indicate that he should be referred as a matter of urgency.

Findings in relation to misconduct and deficient professional performance

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 had particular regard to the authority of Calhaem and the GMC and the observations of Mr Justice Jackson as to the approach to be taken by the Committee in exercising its judgment as to what constitutes misconduct.

The Council relied on two bases of impairment under the Act, namely misconduct and deficient professional performance. It was agreed that the Committee ought to consider these as alternatives and the issue of misconduct first.

Misconduct

The Committee is satisfied that the failings it has found proved, although they occurred in one consultation on 20 November 2009, do, when considered together reach the threshold of misconduct.

Mr Foo saw the pigmentation but did not carry out the full assessment that was required. Having seen it, he then made the consequent but separate failure to refer Patient A. There was a failure to communicate fully his findings and ensure that Patient A was aware of the potential seriousness of the lesion. He failed to make adequate arrangements to ensure that the patient's management was safeguarded after he left the consultation. The Committee took account of the potential seriousness of these failures for the patient. Considering these failures together the Committee is satisfied that they are sufficiently grave to amount to misconduct.

In the light of the agreed approach set out above, the Committee does not proceed to determine whether deficient professional performance is made out, but would add that had it been necessary to do so, it would have not have found that the failings on this one day would have constituted deficient professional performance.

The Committee found Kin Weng Foo guilty of misconduct.

The Committee found Kin Weng Foo not guilty of deficient professional performance.

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 had particular regard to the observations of Mrs Justice Cox in *CHRE-v-Grant* and the four questions listed by Dame Janet Smith in her fifth Shipman report as to how to approach the issue of current impairment.

The Committee is satisfied that the failures by Mr Foo in relation to Patient A's care on one occasion in November 2009 were serious. The incidence of malignant lesions is very rare (possibly only encountered once in a lifetime in optometric practice). However, the consequences of not acting appropriately on such a clinical presentation are potentially life threatening.

In exercising its judgement as to whether Mr Foo is currently impaired by reason of the proved misconduct the Committee has also looked at the factors identified by Mr Justice Silber in *Cohen-v-GMC*. The central misjudgement by Mr Foo was in not dilating Patient A's pupils so as to afford himself the best opportunity of assessing the lesion. The omissions proved in relation to undertaking appropriate testing: making an urgent referral and communicating clearly with the patient are failings that are remediable. The Committee was impressed with Mr Foo's evidence as to the steps he has taken to remediate these failings. It notes that he has undertaken relevant and appropriate continuing education including specific studies on communication, referral and indirect ophthalmoscopy. The Committee was particularly impressed with Mr Foo's description of what he had learned from attending the two clinics with Professor Damato, a leading specialist in the field of ocular oncology. He observed 36 patients with ocular melanoma, far more than the ordinary practitioner can expect to see in a career. Further, he demonstrated in evidence that he had also learned the importance of ensuring that patients understood the diagnosis and professional advice being given.

Although Mr Foo only attended these specific clinics recently, the Committee is satisfied that over the two years that has elapsed since his experience with Patient A, that he has demonstrated insight and learned valuable lessons.

Mr Foo also presented clinical records from four anonymised patients and received further expert evidence on them from Dr Harper and Mr Taylor. While some recording errors were noted in relation to these patients, the Committee accepts the expert view that Mr Foo undertook appropriate testing, used appropriate techniques and made appropriate referrals. The Committee heard a lot of evidence in relation to a photocopy of a photograph of Patient Z's right eye but it has determined that the evidence is incomplete and so poor that no safe conclusions could be drawn.

Considering all matters the Committee is satisfied that Mr Foo's failings from 20 November 2009 are highly unlikely to be repeated and that he does not present a risk to the public.

As the Committee has explained above, it is not persuaded that the clinical misjudgement of Mr Foo was so extraordinarily bad that impairment is made out on the basis of bringing the profession into disrepute or breaching one of the fundamental tenets of the profession.

The Committee therefore found that the fitness of Kin Weng Foo to practise as an optometrist is not impaired.

Warning

The Committee determined that a warning in this case is appropriate. This is because the concerns raised by the case are sufficiently serious to require a formal response. The warning will ensure Mr Foo continues the progress he has made in respect of using appropriate examination techniques, improving his understanding and diagnosis of ocular pathology and communicating fully with patients. The warning will remain on the register for two years.

Chairman of the Committee: Lady Margaret Wall

Signed _____ Date 11 January 2012

Registrant: Kin Weng Foo

Signed _____ Date 11 January 2012

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