

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

GENERAL OPTICAL COUNCIL

F(11)05

AND

NATALIE MURRAY (01-21329)

DETERMINATION OF THE INQUIRY: 12-13 MAY 2011

On 12-13 may 2011, the Fitness to Practise Committee of the General Optical Council met to consider allegations against Natalie Murray.

ALLEGATION

The Council alleges in relation to you, Natalie Murray, a registered optometrist, that:

1. On or about 26 March 2007, at a consultation with Patient A, you:
 - a. Did not conduct an appropriately targeted or full examination given Patient A's condition or known history, in that:
 - i. You did not conduct muscle balance tests other than "DV cover c Rx"; and/or
 - ii. You did not conduct pupil dilation.
 - b. Did not take an adequate history from the patient in that:
 - i. You did not elicit that Patient A had a diagnosis for asthma, despite having recorded "inhalers" under current medication; and/or
 - ii. You did not ask what Patient A was taking "dihydracodine" and "other painkillers" for, despite having recorded both under current medication; and/or
 - iii. You did not ask Patient A what "bp" was for, despite having recorded it under current medication.
 - c. Did not adequately take or record Patient A's ocular history in that you recorded "motor accident 18 years had diplopia surgery to correct no probs now" and:
 - i. You did not ask or record how Patient A was injured; and/or
 - ii. You did not ask or record why diplopia resulted; and/or

- iii. You did not ask or record whether this was a direct injury or nerve palsy; and/or
 - iv. You did not ask or record what surgery was carried out; and/or
 - v. You did not ask or record whether symptoms settled over time or rapidly after corrective surgery.
- d. Did not make adequate records following your consultation with Patient A, in that:
- i. You did not record whether you considered the lesion to be a choroidal naevus, a suspected choroidal malignant melanoma or a choroidal malignant melanoma; and/or
 - ii. You did not record the drug names fully, under current medication.
2. On or about 28 July 2008, at a consultation with Patient A, you:
- a. Did not conduct an appropriately targeted or full examination given Patient A's condition or known history, in that:
- i. You did not conduct muscle balance tests other than "DV cover c Rx"; and/or
 - ii. You did not conduct pupil dilation.
- b. Did not take or record an adequate history from the patient in that:
- i. You did not elicit that Patient A had a diagnosis for asthma, despite having recorded "inhalers" under current medication; and/or
 - ii. You did not ask Patient A what "bp" was for, despite having recorded it under current medication
- c. Did not adequately take or record Patient A's ocular history in that you recorded "motor accident t 18yeas had diplopia surgery to correct no probs now no injinf hes recently" and:
- i. You did not ask or record how Patient A was injured; and/or
 - ii. You did not ask or record why diplopia resulted; and/or
 - iii. You did not ask or record whether this was a direct injury or nerve palsy; and/or
 - iv. You did not ask or record what surgery was carried out; and/or
 - v. You did not ask or record whether symptoms settled over time or rapidly after corrective surgery.
- d. Did not make full or adequate records following your consultation with Patient A, in that:
- i. You did not record your diagnosis of the lesion; and/or
 - ii. You did not record the size of the lesion; and/or
 - iii. You did not record the position of the lesion with precision in that you recorded it as "temporal to the disc" rather than "temporal to the macula"; and/or
 - iv. You did not record your reason(s) for not referring Patient A to a medical practitioner; and/or

- v. You did not record the drug names fully under current medication; and/or
 - vi. You did not record that Patient A had reported to you that:
 - a. His right eye was becoming very dry; and/or
 - b. At night time his right eye was often unfocused so that he had to use full room lighting rather than a bedside lamp to read; and/or
 - c. His right eye was itchy; and/or
 - d. It felt like there was something in his right eye; and/or
 - e. He was not able to produce any tears from his right eye.
 - e. Did not refer Patient A for further investigation or conduct further investigation in circumstances where:
 - i. You had observed a lesion in Patient A's right eye; and/or
 - ii. You were unsure as to whether the lesion in Patient A's right eye was raised; and/or
 - iii. Patient A had reported symptoms to you, as outlined at paragraph 2.d.vi.a-e above; and/or
 - iv. An absolute scotoma was noted in the right nasal field above the horizontal midline of Patient A's right eye; and/or
 - v. The positioning of the absolute scotoma corresponded with the lesion in Patient A's right eye;
3. On or about 7 August 2008, you:
- a. Did not refer Patient A for further investigation or conduct further investigation in circumstances where:
 - i. You had observed a lesion in Patient A's right eye on previous occasions; and/or
 - ii. You were unsure on 28 July 2008, as to whether the lesion in Patient A's right eye was raised; and/or
 - iii. Patient A had reported symptoms to you, on 28 July 2008, as outlined at paragraph 2.d.iv.a-e above; and/or
 - iv. An absolute scotoma was noted in the right nasal field above the horizontal midline both in the visual field tests taken on 7 August 2008 and on 28 July 2008; and/or
 - v. The positioning of the absolute scotoma corresponded with the lesion in Patient A's right eye; and/or
 - vi. Digital fundus images of the right eye had not captured the lesion.
 - b. You did not take responsibility for Patient A's care in that:
 - i. You did not interpret Patient A's threshold visual field test results yourself; and/or
 - ii. You did not obtain digital fundus images of Patient A's right eye that captured the lesion.

By virtue of the matters set out above at paragraphs 1-3 your fitness to practise is impaired by reason of your deficient professional performance and/or misconduct.

DETERMINATION

Findings in relation to the particulars of the allegation

The Committee took account of all the evidence placed before it both written and oral. It also took account of the submissions of Mr Whalley on behalf of the Council and those of Mr Gaisford on behalf of the registrant. It accepted the advice of the legal adviser.

At the commencement of the hearing, Mr Whalley offered no evidence on Particulars 1c in its entirety, 1 d i and 2c in its entirety, The registrant admitted all the particulars of the Allegation as amended save for particular 2 d vi, 2 e ii and iii, 3 a ii and iii and 3 b i.

The Committee made the following findings:

2 d vi: Found not proved. The Committee accepted the evidence of the registrant that if Patient A had specified these symptoms, it was satisfied that it was her practice to record such symptoms accordingly. The Committee also took account of the fact that, in his evidence Patient A was not consistent about what he might have said to the registrant at the time of the examination. The Committee was satisfied that he was a credible witness, but after the passage of time, it was not surprised that Patient A's recollection was a little uncertain.

2 e iii and 3 a iii. Found not proved. Both of these particulars fall because of the findings as outlined above.

2 e ii and 3 a ii: Found not proved. The Committee was satisfied on the evidence from the registrant that it was not her practice to use a question mark to indicate her uncertainty about a particular clinical issue. The Committee was also impressed as to her willingness to make admissions where she felt that she had made a genuine mistake.

3 b i. Found proved. The Committee was satisfied that for the registrant to properly interpret the second visual field test she would have needed more information than the documentation provided by the technician who carried out the test who would have provided the field plot alone rather than the full patient record. The Committee also heard evidence about the very informal process for dealing with visual field test results and since this complaint has been made the practice as a whole has radically changed its arrangement for the proper consideration of such tests.

Findings in relation to deficient professional performance and/or misconduct

The Committee considered the submissions of Mr Whalley on behalf of the Council and those of Mr Gaisford on behalf of the registrant. It accepted the advice of the legal adviser.

Patient A attended for a consultation on 26 March 2007. On this occasion the registrant did not conduct muscle balance tests other than "DV cover c Rx" nor pupil dilation. Further she did not take an adequate medical history from Patient A nor did she make adequate records with regard to recording the drug names of the patient's current medication. At this consultation she did correctly establish the presence of a lesion in Patient A's right eye. Patient A returned for a consultation on 28 July 2008, following the sending of a reminder letter. At this examination, the registrant again did not conduct

muscle balance tests other than “DV cover c Rx” nor an examination of the eyes with pupil dilation. She did not make full or adequate records of her diagnosis of, nor the size of, the lesion. Further, she did not record the position of the lesion nor did she record her reason for not referring the patient. She again did not record the drug names of the patient's current medication. She did not refer the patient for further investigation of the lesion. The patient attended for a further field of vision test and digital fundus image capture of his right eye. The registrant did not interpret the patient's visual field test results and the digital fundus image of the right eye did not capture the lesion.

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

The Committee was satisfied that this was not an exceptional case and, on the basis that these deficiencies only concerned one patient, it concluded that the test for deficient professional performance was not met.

The Committee went on to consider misconduct. The Committee, in particular noted the definition as set out in the case of *Doughty v GDC*, namely “... conduct connected with the profession in which the practitioner concerned has fallen short, by omission or commission of the standards of conduct expected among practitioners and such a falling short must be serious....”

In reaching its decision, the Committee was very much aware that the experts instructed by both parties came to similar conclusions about the significance of the omissions by the registrant to fully investigate the lesion, which she found when she carried out the examinations on 27 March 2007 and 28 July 2008. Mr Stephen Macpherson, on behalf of the Council, in his summary on page 25 of his report, concludes that “a reasonably competent optometrist would be expected to follow up a finding (of a retinal lesion) and a dilated examination would have assisted this process of detailed examination and clearly recorded findings. Pupil dilation is not compulsory (under Scottish GOS rules) for patients under 60 years of age but the option to carry this out is available”. He went on to stress that “the opportunity to review (on 7 August 2008) the pigmented lesion with dilated fundus examination was again not taken up”. He further concludes “the findings indicate to me that the association between the pigmented lesion and the visual field loss should have been made, and even if this was not fully understood, the presence of unexplained visual field loss would prompt referral for ophthalmology”.

Mr Frank Munro, on page 8 of his report, when referring to the examination of Patient A both in 2007 and in 2008, concluded that “failure to carry out dilation is indefensible in these circumstances, especially when there is funding provided for this through the GOS (in Scotland).” He also concludes, in referring to the further visual testing on 7 August 2008, that “This date is pivotal in this case. As stated before, if Mrs Murray had acted on the repeated visual field findings and intervened by carrying out a detailed dilated examination and a further repeat field test she would have been in a much stronger position to make a decision on whether referral was appropriate.”

Both experts concluded that there had been poor record keeping and Mr Munro on page 8 of his report refers to “inconsistent record keeping and poor decision making by Mrs Murray”.

The Committee concluded that, on the basis of this evidence, her omissions were serious and that consequently, this amounted to misconduct. Therefore Natalie Murray is not guilty of deficient professional performance but is guilty of misconduct.

Findings regarding impairment

The Committee took account of the submissions of both parties on the issue of impairment and the testimonials and other documents placed before it. It accepted the advice of the legal adviser.

In reaching its decision, it noted its earlier finding that the registrant was open in admitting the mistakes she had made in carrying out her examinations of Patient A and gave impressive detail of how her practice had now changed as had the practice of her colleagues. The Committee was satisfied that this demonstrated that the registrant has shown considerable insight into her deficiencies and has taken important remedial steps to ensure that her practice is now up to the standard of a reasonably competent optometrist. The Committee noted her extensive CET record and her ongoing commitment to further study. The Committee concluded that her deficiencies were capable of remediation and that, on all the evidence before it she has taken appropriate steps to remedy her deficiencies. It was satisfied that, by taking the steps that she has, and in demonstrating the insight that she has shown, there is no likelihood of these matters being repeated in the future. The Committee has therefore concluded that today and, looking forward from today, the registrant’s fitness to practise is not impaired.

Consequently, the Committee found that the fitness of Natalie Murray to practise as an optometrist is not impaired.

The Committee considered whether it would be appropriate to issue a warning. The Committee concluded in the circumstances of this case that it is not necessary.

Chairman of the Committee: Sir Alistair Graham

Signed _____ Date 13 May 2011

Registrant: Natalie Murray

Signed _____ Date 13 May 2011

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.