New Zealand Health Practitioners Disciplinary Tribunal

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DECISION NO: 525/Opt12/220P

IN THE MATTER of the Health Practitioners Competence Assurance Act 2003

-AND-

IN THE MATTER of disciplinary proceedings against **DESMOND JOHN WHITE** registered Optometrist, formerly of Whangarei

BEFORE THE HEALTH PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Ms K G Davenport (Chair)
Ms A Morgan, Associate Professor R Jacobs, Mr R Gordon and Ms A Kinzett (Members)

Ms G Fraser (Executive Officer)
Ms T Murray (Stenographer)

HEARING: Held in Whangarei Monday 25 March 2013

APPEARANCES: Ms J Hughson for the Professional Conduct Committee

Mr G Swanepoel for the practitioner

Introduction

1. Mr White is an optometrist. He formerly practised in Whangarei and now resides in Australia. He was charged as follows:

> *"TAKE NOTICE that a Professional Conduct Committee ("the Committee") established by the Optometrists and Dispensing Opticians Board under section 71 of the Health Practitioners Competence Assurance Act 2003 ('the Act") has made a determination in accordance with section 82(3)(a) of the Act.*
>
> *Pursuant to section 91 of the Act the Committee has reason to believe that grounds exist entitling the New Zealand Health Practitioners Tribunal to exercise its power under section 100 of the Act.*
>
> ***Particulars of Charge of Professional Misconduct***
> *The Professional Conduct Committee charges that Desmond John White ("Mr White"), Optometrist formerly of Whangarei:*
>
> *On or about 16 December 2010 and/or in the period between 16 December 2010 and 7 February 2011 Mr White failed to refer his patient, Jared McGiven ("Mr McGiven"), in a timely manner to an ophthalmologist for the assessment and/or treatment of an abnormality which he had identified in Mr McGiven's right eye in that Mr White did not refer Mr McGiven to an ophthalmologist until 7 February 2011.*
>
> *The conduct alleged above amounts to professional misconduct under section 100 of the Act."*

2. Mr White acknowledged that the charge did amount to professional misconduct. He cooperated with the Professional Conduct Committee ("PCC") to produce an agreed Summary of Facts for the Tribunal.

3. The statements of facts is set out below:

> ***AGREED SUMMARY OF FACTS***
>
> *Professional Background*
>
> *1. Mr Desmond John White is a registered optometrist. He is registered in the Optometrist Scope of Practice with the Optometrists and Dispensing Opticians Board ("the Board"). Mr White holds an active, current Annual Practising Certificate with the Board.*
>
> *2. Until mid-2012 Mr White owned and practised optometry from Visualeyez Optometrists Limited in Whangarei. Mr White has since sold the business and he now lives and works in Australia for Bausch and Lomb.*

3. Mr White holds a DipOptom (South Africa) and he is a MBCO/MCOptom (Member of the British College of Optometrists) (1 February 1996).

4. Mr White first registered in New Zealand on 14 June 1999.

The Charge

5. The charge before the Tribunal, which Mr White admits, alleges professional misconduct as follows:

> *On or about 16 December 2010 and/or in the period between 16 December 2010 and 7 February 2011 Mr White failed to refer his patient, Jared McGiven ("Mr McGiven") in a timely manner to an ophthalmologist for the assessment and/or treatment of an abnormality which he had identified in Mr McGiven's right eye in that Mr White did not refer Mr McGiven to an ophthalmologist until 7 February 2011.*

Admitted Factual Basis for the Charge

6. The facts in respect of the charge are set out below and are admitted by Mr White.

7. At the time of the events specified in the charge Jared Roy McGiven ("Mr McGiven") was 16 years old and a student at Pompallier College in Whangarei. Mr McGiven turned 17 on 24 February 2011. He is now 19 years of age.

8. On or around 6 December 2010 Mr McGiven went for his learner's driver's license. He failed the eyesight test which is one of the test components. This surprised Mr McGiven and his mother because Mr McGiven had always boasted about his 20/20 vision. Mr McGiven was told that he needed to go and see an optometrist to have his eyes checked. Mr McGiven's mother, Mrs Susan Bryone Jane McGiven ("Mrs McGiven") wanted her son to see an optometrist as soon as possible and so she phoned Visualeyez/Mr White (Mr White was her optometrist) and made an appointment for her son to see him.

9. Around three days later, on 9 December 2009 Mr McGiven attended a consultation with Mr White at Visualeyez Optometrists in Whangarei ("the first consultation"). The consultation time was 10:10 hours. Mr McGiven attended the first part of the consultation by himself while his mother waited in the waiting room. Mr White examined Mr McGiven's eyes and detected an abnormality in the right eye. The visual field/perimetry test identified a right superior field defect. The retinal examination showed a black pigmented spot inferior to the macular with some sort of retinal involvement.

10. Mr White told Mr McGiven that there "something a bit odd" with his right eye. Mr White then took Mr McGiven to the adjacent consultation room where he took a photo of Mr McGiven's right eye. Mr White then called Mrs McGiven into the room and he showed her the photograph he had taken, on the screen. The photograph print-out shows that it was taken on 9 December 2010 at 10:40 hours. The photograph showed a pigment line running through the macula in Mr McGiven's right eye and thereby demonstrated a retinal detachment. However Mr White did not diagnose a retinal detachment.

11. Mr White told Mrs McGiven and her son that in view of the abnormality he had detected he wanted to take some more and better photographs. He told them he wanted Mr McGiven to return for a second appointment at which time he would take further photographs with the eye dilated. Mr White explained that the dilated fundus examination he proposed when Mr McGiven returned to have further photographs taken would involve dilating Mr McGiven's right eye using drops.

12. In his examination report for the first consultation Mr White recorded "Anterior: clear corneas" and "Posterior; cd 05/05, clear med & mac, right mac damage? [macular damage] Black pigment spot inf [inferior] to mac, query pvd [posterior vitreous detachment] ?? Tca for dfe [dilated final examination]". Under "Advice" Mr White recorded "ph va right 6/15, advised right va worse, amblyopia? [this is commonly known as "lazy eye"], dl12 without spex given book dfe". Under "Management" Mr White recorded "16/12/10 dfe + photos" and under "Dispensing" he noted "2nd opinion from bks [this was a reference to Dr Brian Kent-Smith, ophthalmologist in Whangarei], refer". Mr White recorded Mr McGiven's unaided right eye vision as being 6/19 and left eye vision as being 6/6. Under "Perimetry" Mr White recorded "right sup defect".

13. Mr White did not record a retinal detachment as a diagnosis or possible diagnosis in Mr McGiven's clinical notes for the examination. His differential diagnosis of the patient record for this consultation included amblyopia and posterior vitreous detachment (PVD).

14. As at 9 December 2010 Mr White considered that he did not know whether he was dealing with a longstanding event or amblyopia in Mr McGiven's right eye. When he saw the black spot Mr White did not know what this was but he admits that he knew something was wrong.

15. A second appointment was made (for the purpose of carrying out a dilated fundus examination and taking further retinal photographs) for seven days later, being on 16 December 2010 ("the second consultation").

16. Mr McGiven accompanied by his mother, attended Mr White for the second consultation, on 16 December 2010. Mr White dilated Mr McGiven's right eye and took more photographs. The photographs showed the defect which Mr White had detected at the first consultation. Mr White suggested to Mr McGiven and his mother that it was probably nothing to worry about and they should wait three months following which Mr McGiven should return and have more photographs taken to see if there had been any change in the abnormality he had detected. Mrs McGiven told Mr White that she did not want to wait for three months as she and her son were really worried about what the abnormality was. Mrs McGiven asked Mr White if it could be cancer but Mr White said that the chances of that were very small. Mr White said he did not know what the abnormality was but he queried whether it was something Mr McGiven had always had.

17. Mr White then told Mr McGiven and his mother that he had a friend who was an eye specialist and that he would email the photographs to him and ask him to have a look at them. Mr White explained that if his eye specialist friend had any concern about the photographs then he (Mr White) would contact Mr McGiven if he (the eye specialist) needed to see him. Mr White pointed out that as it was so close to Christmas he may

not hear anything until early January 2011 as both he and his eye specialist friend would be on holiday.

18. *In his clinical record for the consultation on 16 December 2010 Mr White recorded only "dfe, as per 9/12 notes, possible retinoschisis?? Refer & send photo to bks – des".*

19. *After the consultation on 16 December 2010 Mr White placed Mr McGiven's file in his "jobs to be done" tray so that the photographs could be sent to Dr Kent-Smith to have a look at.*

20. *On or about 21 December 2012 Dr Brian Kent-Smith, ophthalmologist of Eye Specialists Day-Surgery Eye Centre in Whangarei and the eye specialist friend Mr White had mentioned to Mr McGiven and his mother at the second consultation, happened to call in to Visualeyez for a casual visit to see Mr White before Christmas. Dr Kent-Smith saw Mr White and Mr White showed him his new camera. In the course of this casual visit, Mr White showed Dr Kent-Smith (on the screen) one of the photographs he had taken of Mr McGiven's right eye. When Mr White asked Dr Kent-Smith if this warranted referral Dr Kent-Smith told Mr White that he must refer his patient to him so he could examine the patient and make a diagnosis. Dr Kent-Smith recalls pointing out the diagonal pigmented line which was evident on the image he reviewed on screen.*

21. *In Mr McGiven's clinical records Mr White recorded this visit from Dr Kent-Smith as follows "21/12/10 bks came in to; look for some sunnies, showed photo of right eye, refer".*

22. *Mr McGiven and his family went camping over the Christmas/New Year period 2010-2011. On their return from camping on or about 10 January 2011, Mrs McGiven's mother asked her if she had heard anything from Mr White about Mr McGiven's eye. Mrs McGiven told her mother she had not but that Mr White was probably still on holiday and may not yet have had a chance to show his eye specialist friend the photographs.*

23. *Encouraged to so by her mother, a few days later Mrs McGiven decided to telephone Visualeyez. This was in the second or third week of January 2011. She and Mr McGiven were becoming more anxious about the abnormality as time went on but at the same time they had felt reassured by Mr White's advice that it was probably nothing to worry about and given his indication that he was prepared to wait three months before taking more photographs.*

24. *When she phoned Visualeyez Mrs McGiven was told that Mr White was not available at that time but that he (Mr White) would call her back. Mr White called Mrs McGiven back that afternoon. Mr White told Mrs McGiven that his friend and colleague Dr Kent-Smith thought it would be a good idea for him to take a look at her son's eye. Mrs McGiven was shocked to hear this because it indicated to her that there was indeed a problem with her son's right eye. Mrs McGiven asked Mr White what would happen now and Mr White said he would need to send a referral letter to Dr Kent-Smith and that an appointment could then be scheduled for her son to see Dr Kent-Smith. Mr White told Mrs McGiven that it would take about two weeks before they would receive an appointment from Dr Kent-Smith's rooms.*

25. *Mr White did not tell Mrs McGiven that one option was for her make an appointment for her son, directly with Dr Kent-Smith rather than wait for him (Mr White) to refer her son.*

26. *It was not until 07 February 2011 at 15.05 hours (around eight weeks from the date on which Mr White first saw Mr McGiven (9 December 2010) and seven weeks from the date of the second consultation (16 December 2010)), that Mr White faxed a referral letter for Mr McGiven to Dr Kent-Smith at his rooms at Eye Specialists Day Surgery Eye Centre in Kamo Road, Whangarei. A copy of the referral letter was also faxed to Dr Tim Cunningham, Mr McGiven's GP.*

27. *In his referral letter to Dr Kent-Smith Mr White reported that he had examined Mr McGiven on 16 December 2010. Mr White acknowledges that he made no mention of the first consultation on 9 December 2010 in the referral letter. Further, Mr White noted that this was "the young man whose fundus photograph" he (Dr Kent-Smith) had shown him when he "popped in a number of weeks back". Mr White stated under the heading "Assessment" as follows "IOP: 12/12, clear corneas, cd 05/05, right macular damage? Possible vitreous detachment, black pigment spot inferior to mac". Under the heading "Management" Mr White wrote "ph/va right 6/15, advised right amblyopia, d/12 without spexs given." Mr White asked Dr Kent-Smith to contact the patient directly to book an appointment.*

28. *Although the referral letter refers to Mr White's possible diagnoses of amblyopia and a possible posterior vitreous detachment Mr White acknowledges that he made no mention in that letter of the right eye superior defect he had noted in his examination notes for Mr McGiven's consultations on 9 December 2010. Further, there was no mention of a diagnosis having been made by Mr White of a retinal detachment. That was because Mr White had not made that diagnosis.*

29. *Subsequent to faxing the referral letter, on 8 February 2011 Mr White emailed to Dr Kent-Smith's room the digital image/photograph he had taken of Mr McGiven's right eye on 9 December 2010.*

30. *When referring Mr McGiven to Dr Kent-Smith on 7 February 2011 and when emailing the photograph taken on 09 December 2010 to Dr Kent-Smith on 08 February 2011 Mr White did not provide the retinal photographs he had taken with his (new) camera at his consultation with Mr McGiven on 16 December 2010. Those photographs were never provided to Dr Kent-Smith as part of Mr McGiven's referral.*

31. *On or about 9 or 10 February 2011 Mrs McGiven was contacted by Dr Brian Kent-Smith's rooms notifying her of an appointment for Mr McGiven for 16 February 2011. This was followed up by letter. Mrs McGiven was lead to understand at that time that Dr Kent-Smith had only recently received Mr White's referral, which was in fact the case.*

32. *Mr McGiven did not receive notification from Mr White/Visualeyez about his scheduled appointment with Dr Kent-Smith on 16 February 2011.*

33. *Mr White admits that on 16 December 2010 and/or in the period between 16 December and 07 February 2011 he failed to refer his patient, Jared McGiven in a timely manner to an ophthalmologist for the assessment and/or treatment of the abnormality which he had identified in Mr McGiven's right eye in that he did not refer Mr McGiven to an ophthalmologist until 07 February 2011.*

Subsequent Events

34. *Mr McGiven and his mother went to the consultation with Dr Kent-Smith on 16 February 2011. Dr Kent-Smith promptly diagnosed a right retinal detachment. During the consultation Dr Kent-Smith telephoned Dr Philip Polkinghorne, ophthalmologist and vitreo-retinal specialist at Auckland Eye in Newmarket, Auckland (and Associate Professor in Clinical Ophthalmology) and arranged for surgery to be performed on Mr McGiven's eye the following week.*

35. *Following the consultation Dr Kent-Smith wrote a referral letter to Dr Polkinghorne. The letter is incorrectly dated 8 February 2011, which was the date when Dr Kent-Smith first wrote to Mr McGiven to notify him of his appointment on 16 February 2011. The correct date of Dr Kent-Smith's letter to Dr Polkinghorne was 16 February 2011.*

36. *In his referral letter to Dr Polkinghorne (copied to Mr White) Dr Kent-Smith recorded that Dr Polkinghorne had agreed to do a right retinal detachment repair at Mercy Hospital in Auckland "next week Tuesday". Dr Kent-Smith recorded that he had discussed the prognosis with Mr McGiven and his mother and that they understood the detachment was long-standing and that Mr McGiven was unlikely to recover 6/6 (20/20) vision. Dr Kent-Smith stated that "we are hoping to preserve the current level of vision at least, and possibly get a small improvement".*

37. *The following day, on or about 17 February 2011 Mr McGiven received confirmation of a pre-operative (right retinal detachment repair) appointment with Dr Polkinghorne at Auckland Eye on Tuesday 22 February 2011 followed by an admission for surgery at Mercy Hospital in Epsom, Auckland at 10.00am that day.*

38. *Mr McGiven presented to Dr Polkinghorne on 22 February 2011 with a macula-off or bisecting retinal detachment from a large retinal break which was complicated by subretinal bands and a stiffened retina.*

39. *On 22 February 2011 Mr McGiven had surgery performed on his right eye by Dr Polkinghorne (combined vitrectomy/retinal detachment surgery with scleral buckle). Dr Polkinghorne performed a 23-gauge vitrectomy and under heavy liquids reattached the retina, mobilising the peripheral retina as required. Mr McGiven was told that the surgery had been as difficult as Dr Polkinghorne had expected it would be; the surgery had involved the placement of a circumferential 276 buckle in the inferotemporal quadrant to support the retina and then the application of Endolaser photocoagulation to the retinal break. The heavy oil was removed and replaced with air and subsequently silicone oil was injected into the vitreous cavity.*

40. *At one of Mr McGiven's check-ups with Dr Kent-Smith and Dr Polkinghorne post-surgery in February 2011 both doctors agreed that Mr White should have referred Mr McGiven to an ophthalmologist immediately when he did not know what the abnormality he had detected was.*

41. *On or about 3 March 2011 Mrs McGiven went to see Mr White at Visualeyez to complain about his care of Mr McGiven and in particular the time it had taken him to action a referral for her son to Dr Kent-Smith. Mrs McGiven was very upset and Mr White apologised to Mrs McGiven for the delay. In Mr McGiven's clinical records Mr White recorded "3/3/11 Mum, Sue came in today, not happy that I took so long to refer to bks, I apologised for my failure to refer when advised i would,*

genuine mistake due to misfiling of records, i will write letter apology – des."

42. *On 16 March 2011 Mr White wrote a letter to Mr McGiven and his mother outlining changes he had made to Visualeyez procedures to prevent "any future delay of patient referrals" from occurring again. Mr White also apologised "that Jared's referral fell through cracks in our system'.*

43. *Although Mr McGiven's right retina was flat in the perioperative period, in April 2011 Dr Polkinghorne noted there was photo fluid appearing underneath the retina and he carried out further surgery on Mr McGiven on 7 April 2011. The silicone oil was removed from Mr McGiven's eye under general anaesthesia on 3 May 2011 at which time Dr Polkinghorne performed additional laser treatment and tamponaded the retina with a temporary agent (C3F8).*

44. *There followed a period of further surgeries for Mr McGiven (five surgeries in the four month period from 22 February 2011) and extensive follow up visits to Dr Polkinghorne in Auckland and Dr Kent-Smith in Whangarei, which continue to this day.*

45. *On 3 December 2011 Mr McGiven had his right eye removed by Dr Kent-Smith at Kensington Hospital in Whangarei. His eye was replaced with an artificial eye. Mr McGiven is now permanently blind in his right eye.*

46. *Dr Polkinghorne considers that had Mr McGiven undergone his first surgery earlier a better outcome would have been expected in terms of achieving better vision. By the time of his surgery on 22 February 2011 the scarring was significant and this contributed to the poor outcome of the surgery.*

Expert Opinion

47. *Mr Peter Grimmer, Registered Optometrist of Wellington was asked by the PCC to provide an independent expert opinion on the matter the subject of the charge. Mr Grimmer is qualified BSc DipOpt CertOcPharm and TAPIOT FAAO and has practised as an optometrist in general practice (with special interest in anterior segment eye disease and contact lens practice) since 1979.*

48. *In Mr Grimmer's opinion given Mr McGiven's poor vision in his right eye and the macula appearance (abnormality) as at 9 December 2010 the expectation would have been for Mr White to have dilated the patient immediately unless the patient refused. Mr White did not do this on 9 December 2010 but he did arrange for the patient to return, albeit a week later for a dilated fundus examination and to take more retinal photographs.*

49. *Mr White admits that by 16 December 2010 he had a clearer picture of Mr McGiven's poor vision and macula abnormality having conducted a dilated fundus examination and taken more retinal photographs that day. In Mr Grimmer's opinion if, as at that date, Mr White had recognised the inferior retinal detachment then the normal and/or expected process would have been for Mr White to have spoken to a medical eye specialist (preferably with a vitreo-retinal sub specialty) immediately that day to find out how soon the specialist would want to see the patient and schedule surgery. This would be in an attempt to save the patient's*

current standard of vision. In Mr Grimmer's opinion in the event Mr White made a diagnosis of retinal detachment that day then there should have been a referral of Mr McGiven to an ophthalmologist immediately (within 24 hours).

50. *Mr Grimmer considers that in fairness to Mr White Mr McGiven's retinal detachment presentation in December 2010 was not a typical rhegmatogenous retinal detachment. However in his view the colour difference between the two halves of the retina as shown on the photographs together with the corresponding field defect should have pointed Mr White to the correct diagnosis. On that basis in Mr Grimmer's view Mr White should have been in a position to make the correct diagnosis by 16 December 2010 and make an immediate referral to an ophthalmologist.*

51. *Mr White's clinical notes for Mr McGiven's consultations on 9 and 16 December 2010 do not record a retinal detachment diagnosis and Mr White acknowledges that he did not recognise and/or diagnose a retinal detachment. However Mr White does acknowledge that by 16 December 2010 he had a 16 year old (ie. young) patient with poorish right eye pin hole vision, an abnormal macula, a photograph that clearly showed a different coloured retina with lines in it and a corresponding superior field defect. In Mr Grimmer's opinion these circumstances should have provoked concern in Mr White and even accepting he may have not been able to diagnose the cause of these signs/symptoms at that time, it would have been prudent, appropriate and expected practice for him to have referred his patient to a medical eye specialist (an Ophthalmologist) within 7 to 10 days. In Mr Grimmer's view Mr White's failure to do so in Mr McGiven's case amounted to a significant failure to meet an acceptable professional standard. Mr White acknowledges and accepts that view.*

52. *Mr Grimmer has observed that Mr White recorded other differential diagnoses in his notes for the appointments on 09 and 16 December 2010.*

53. *Mr White's primary diagnosis was amblyopia. This is the unilateral or rarely bilateral decrease in best corrected visual acuity caused by form vision deprivation and/or binocular interaction for which there is no pathology of the eye or visual pathway. In Mr Grimmer's view, Mr McGiven's right eye showed definite pathology as at 9 and 16 December 2010 and therefore the diagnosis of amblyopia was not a possibility in Mr McGiven on those dates.*

54. *Mr White also included posterior vitreous detachment in his differential diagnosis on 9 and 16 December 2010. Posterior vitreous detachment occurs when the jelly-like substance within the body of the eyes liquefies and shrinks. When this occurs the posterior face pulls away from the retina and eventually collapses. The hallmark signs for this condition are a lot of floaters within the body of the eye including a Weiss ring floater (the previous attachment area of the vitreous around the optic disc) and the posterior face is visible in the slit lamp beam in a dilated eye. The signs include sudden onset flashes and floaters. This condition is nearly always in the older eye (post 50 years). In Mr Grimmer's opinion, Mr McGiven did not have any of the presenting symptoms for posterior vitreous detachment on 9 and/or 16 December 2010, none of the signs of this condition and he did not fit within the usual demography for the condition on those dates.*

55. *In his notes for the 16 December 2010 consultation and also in interview with the Professional Conduct Committee on 25 June 2012 Mr White also offered retinoschisis in his differential diagnoses for Mr McGiven. This condition is the splitting of the sensory retina into two layers. There are two types of retinoschisis; degenerative and congenital. Degenerative retinoschisis occurs in about 5% of the population over the age of 20 years. The split occurs in the peripheral retina and is nearly always asymptomatic. Congenital retinoschisis (usually called Juvenile X linked retinoschisis) is characterised by a bilateral maculopathy and the vision in both eyes will be poor (Kanski Jack J Clinical Ophthalmology A systematic approach 5th edition, Butterworth Heinemann pages 522; 363 and 509).*

56. *In Mr Grimmer's opinion Mr McGiven did not have and could not have had congenital retinoschisis as this is a bilateral condition as Mr White's examinations on 9 and 16 December 2010 showed that Mr McGiven's problem was only in his right eye. Further Mr McGiven's photographs taken by Mr White on those dates do not show the immobile peripheral elevated symmetrical bubble seen in cases of degenerative retinoschisis. Also, Mr McGiven's macular was involved and this is rarely involved in such cases. In Mr Grimmer's opinion retinoschisis was not a possibility in Mr McGiven's presentation on 9 and 16 December 2010 respectively.*

57. *Mr Grimmer considers that the diagnostic possibilities open to Mr White in Mr McGiven's case as at 16 December 2010 were retinal detachment, possibly some kind of macula dystrophy (however these are usually bilateral) or any condition that might cause an altitudinal visual field defect, most of which can be ruled out in Mr McGiven's case, because of the absence of other clinical signs.*

58. *In summary, in Mr Grimmer's opinion, on or about 16 December 2010 and/or in the period between 16 December 2010 and 7 February 2011, Mr White's admitted failure to refer his patient, Mr McGiven, in a timely manner to an ophthalmologist for assessment and/or treatment was a significant departure from the standards expected of a registered optometrist practising optometry in New Zealand in 2010 and early 2011. Further it was conduct which was contrary to his patient, Mr McGiven's welfare. In Mr Grimmer's opinion a period of seven to eight weeks was an entirely unreasonable and unacceptable timeframe within which to refer a patient with the clinical picture Mr McGiven had as at 9 and/or 16 December 2010 and further, in circumstances where an ophthalmologist (Dr Kent-Smith) had advised Mr White that he must refer his patient to him for diagnosis and treatment as early as 21 December 2010; and where the patient's mother had contacted him in mid January 2011 to ask about a referral including the process and timetable around that.*

Admission

I, DESMOND JOHN WHITE, registered optometrist of Whangarei, confirm and admit that agreed summary of facts, and the disciplinary charge of professional misconduct. Further, I admit that the charge amounts to professional misconduct.

4. In addition to this evidence the Tribunal also received a bundle of documents which included copies of the Code of Ethics for the Optometrists and

Dispensing Opticians Board, Mr White's notes for his two consultations with Mr McGiven on the 9 and 16 December 2010, a colour copy of his initial photograph of Mr McGiven's eye (exhibit 3) and (on disk) the three photographs of Mr McGiven's eye taken by Mr White on 16 December 2010. The Tribunal has been given a copy of the referral letter by Mr White to Dr Brian Kent-Smith, an ophthalmologist in Whangarei which had as an attachment the photograph taken on 9 December 2010 but not the photographs taken on 16 December 2010.

5. Despite the acknowledgement by Mr White that the conduct set out in the charge amounts to professional misconduct, the decision as to whether the conduct amounts to professional misconduct is always a decision for the Tribunal.

The Law

6. A practitioner may be disciplined if the conduct complained of falls within one of the categories set out in s.100. The sections which are relevant to this case are s.100 (1) (a) and s.100 (1) (b). They are set out below.

> *"Section 100: Grounds on Which a Practitioner May Be Disciplined*
>
> *1. The Tribunal may make one or more of the orders authorised by Section 101 if, after conducting a hearing on the charge laid under section 91 against a health practitioner it makes one or more findings that:*
>
> *(a) The practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal, amounts to malpractice or negligence in relation to the scope of practice in respect of which the practitioner was registered at the time that the conduct occurred;*
>
> *(b) The practitioner has been guilty of professional misconduct because of any act or omission that, in the judgment of the Tribunal has brought or is likely to bring discredit to the profession that the Health Practitioner practised at the time that the conduct occurred or ……"*

7. As set out above, a health professional is guilty of professional misconduct in terms of section 100(1) if the conduct:

   (a) Amounts to malpractice or negligence in the way that they discharge their professional responsibilities; or

   (b) The acts or omissions will or are likely to bring discredit to the practitioner's profession regardless of whether or not they occur within a practitioner's scope of practice.

8. Negligence, in the professional disciplinary context, does not require the prosecution to prove that there has been a breach of a duty of care and damage arising out of this as would be required in a civil claim. Rather, it requires an analysis as to whether the conduct complained of amounts to a breach of duty in a professional setting by the practitioner. The test is whether or not the acts or omissions complained of fall short of the conduct to be expected of an optometrist in the same circumstances as Mr White. This is a question of analysis of an objective standard measured against the standards of the responsible body of a practitioner's peers.

9. As Justice Elias said in *B v The Medical Council*[1]:

> *"The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this court indicates that usual professional practice, whilst significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the court to determine, taking into account all the circumstances including not only practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards".*

10. Section 100(1)(b) requires the Tribunal to determine whether or not the act or omission has brought or is likely to bring discredit to the profession. The

[1] (HC, Auckland, HC11/96, 8 July 1996, Elias J)

Nurses Act 1977 contained a similar clause and this was considered by the Gendall J in *Collie v Nursing Council of New Zealand*[2]. He said:

> *"To discredit is to bring harm to the repute or reputation of the profession. The standard must be an objective standard for the question to be asked by the Council being whether reasonable members of the public, informed and with knowledge of all the factual circumstances, could reasonably conclude that the reputation and good-standing of the nursing profession was lowered by the behaviour of the nurse concerned."*

11. The provisions contained in s.100 sit within the body of earlier well established case law on professional discipline. The statements made by Judges such as Gendall J in *Collie (supra)* and those set out below, still apply when considering the definition of malpractice and negligence.

12. Justice Jeffries described professional misconduct in *Ongley v The Medical Practitioners Disciplinary Tribunal*[3] as the answer to the following question:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting medical misconduct? With proper diffidence, it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency…"*

13. Justice Venning in *McKenzie v The MPDT*[4] described the test of professional misconduct as follows:

(Paragraph 71)

> *"In summary, the test for whether a disciplinary finding is merited is a two-stage test based on first, an objective assessment of whether the practitioner departed from acceptable professional standards and secondly, whether the departure was significant enough to attract sanction for the purposes of protecting the public. However, even at that second stage it is not for the Disciplinary Tribunal or the Court to become engaged in the consideration of or to take into account subjective consideration of the personal circumstances or knowledge of the particular*

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2 (HC, Wellington AP 300/99, 5 September 2000)
3 [1984] 4 NZAR 369 at 375
4 (HC Auckland, CIV 2002-404-153-02;12/06/03)

> *practitioner. The purpose of the disciplinary procedure is the protection of the public by the maintenance of professional standards. That object could not be met if in every case the Tribunal and the Court was required to take into account subjective considerations relating to the practitioner."*

14. Decisions such as these and other cases under the Medical Practitioners Act 1995 and its predecessor the Medical Practitioners Act 1968 established a 2 stage test for determining professional misconduct. The test provides:

(a) Was the conduct complained of such that an optometrist in the same vocational area as the optometrist charged considers that the conduct fell (significantly) short of the conduct that was to be expected of a reasonably competent optometrist? and;

(b) If the answer to 1. is "yes"; then did this finding warrant the imposition of a disciplinary sanction for the purpose of protecting the public and or maintaining standards and or punishing the optometrist?

15. A commentary on the second part of this test can be found at paragraph 68 and 70 of this Tribunal's decision in *Nuttall*[5] and in cases such as *Pillai v Messiter*[6].

16. The PCC submitted that:

> *"26. Mr White's conduct in this case fell seriously short of the appropriate standard of care required. This was a case where Mr White has admitted that as at 16 December 2010 he had a 16 year old patient with poorish right eye pin hole vision, an abnormal macula, a photograph that clearly showed a different colour retina with lines in it and a corresponding superior field defect; and whom he should have referred to a medical eye specialist with 7 to 10 days (on the basis of Mr Grimmer's expert opinion). Yet he did not do so. Even when, on 21 December 2010 Mr White was visited by ophthalmologist Dr Brian Kent-Smith who viewed a retinal photograph of Mr Given's right eye and told him he must refer his patient to him for diagnosis and treatment, Mr White did not action a referral. Then when Mr White was contacted by his patient's mother in mid-January 2011 to ask about a referral and the process and timeframe for that, Mr White still did not action a referral to Dr Kent-Smith. A referral was not actioned until 7 February 2011.*

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5 PCC v Nuttal [decision 8/Med04/03P]
6 (1989) 16 NSWLR 197

27. It is submitted that in all the circumstances of this case a period of seven to eight weeks within which to refer a patient with Mr McGiven's clinical picture to an ophthalmologist was an entirely unreasonable and unacceptable timeframe and amounted to a significant falling short of accepted standards. Mr White's conduct, it is submitted, was completely contrary to his patient's best interests and had the potential to cause him significant harm.

28. When Mr White did finally action a referral of his patient to an ophthalmologist he omitted to refer to the consultation he had first had with Mr McGiven on 9 December 2010, referring only to his consultation with Mr McGiven on 16 December 2010. Further, Mr White did not include with his referral letter (or at any other time) the three retinal photographs he had taken on 16 December 2010 (he included only the photograph dated 9 December 2010). Nor did Mr White refer to the right eye superior defect he had noted in his examination notes for Mr McGiven's consultation on 9 December 2010".

17. Mr Swanepoel for Mr White did not contest the conclusion that the conduct was professional misconduct but submitted that the conduct complained of was more negligence and involved a significant aspect of administrative failure rather than malpractice. However, he did acknowledge that there was also a misdiagnosis.

18. In having considered these submissions the Tribunal considered that the events amounted to professional misconduct by Mr White.

19. In having considered these submissions, the facts and the law, the Tribunal considered that the charge had been established and warranted disciplinary sanction and amounted to professional misconduct under s.100(1)(a) being both negligence and malpractice.

20. Having found Mr White guilty of professional misconduct the Tribunal must consider the appropriate penalty. The law applying to the imposition of a penalty is as follows:

Principles of Sentencing

21. A penalty must fulfill the following functions. They are:

a) **Protecting the public**.

S.3 of the Health Practitioners Competence Assurance Act sets out the purposes of the legislation. The principal purpose of the Act is "to protect the health and safety of members of the public by providing for mechanisms

to ensure that health practitioners are competent and fit to practise their professions."

b) **Maintenance of professional standards**.

This was emphasised in *Taylor v The General Medical Council*[7] and *Dentice v The Valuers Registration Board*[8].

c) **Punishment.**

While most cases stress that a penalty in a professional discipline case is about the maintenance of standards and protection of the public there is also an element of punishment – such as in the imposition of a fine. see s.101 (2) or censure. See for example the discussion by Dowsett J in *Clyne v NSW Bar Association*[9] and Lang J in *Patel v Complaints Assessment Committee*[10]).

d) Where appropriate, rehabilitation of the practitioner must be considered – see *B v B*[11].

22. The comments of Justice Gendall in *PCC v Martin*[12] are helpful in considering penalty. He said at paragraph 24 and 26:

> *"[24] Removal from the Register or striking-off may have the consequences of a punishment but as has been made clear in many cases the order is not made by way of punishment but because the person was not a proper and fit person to remain registered as a professional person. If the conviction and the actions of the practitioner lead to the conclusion that he/she is not fit to be registered as a nurse, or to practise in a particular profession, then de-registration or suspension is inevitable.*
>
> …
>
> *[26] The appropriate starting point seems to me to ask: "What orders will protect the public, through advancing the properly responsible standards and practice of nursing?"*

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7 [1990] 2 All ER 263
8 [1992] 1 NZLR 720
9 (1960) 104 CLR 186 at 201-202
10 HC Auckland CIV 2007-404-1818; Lang J; 13/8/07
11 HC Auckland, HC 4/92 6/4/93; [1993] BCL 1093
12 Supra

> *rather than to ask: "Should the professional be punished again?".*

23. Also relevant are the comments of Randerson J in *Patel v Dentists Disciplinary Tribunal*. Randerson J stressed that the Tribunal had to consider the "alternatives available to it short of removal and to explain why lesser options have not been adopted in the circumstances of the case"[13].

24. The Tribunal has examined each of these principles with care. It considers the maintenance of professional standards and protection of the public requires a response from the Tribunal in this case and at the more serious end of the penalty scale.

25. Mr Swanepoel advanced a number of factors in mitigation. First he advanced evidence in the form of an email to Dr Brian Kent-Smith that mis-diagnosis may not have contributed to the loss of Mr McGiven's eye. He submitted that there was no evidence of the link between the omission to refer expeditiously and the final outcome. He said that Mr White had unreservedly apologised and acknowledged his error. He told the Tribunal that Mr White had obtained a position as an optometrist in Brisbane but because of the ongoing unresolved complaint he was not able to register as an optometrist in Australia. He was then unemployed for a number of months. He has recently found employment as a sales manager working for a company that supplies contact lenses. He does not require an optometry qualification to do that job. Mr Swanepoel submitted that Mr White had limited funds, and was the sole breadwinner in his family with one child and had no capital as a result of the move to Australia. He submitted that the appropriate penalty for Mr White was a censure and a small fine given the limited means of Mr White.

Discussion

26. Ms Hughson submitted that the penalty should be censure, a fine, the imposition of conditions upon Mr White's practice to ensure that he was practising at a safe standard and under supervision. She submitted that a fine in the vicinity of

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[13] at para 30 from *Patel v Dentists Disciplinary Tribunal* [HC Auckland AP 77/02; 8/10/02 Randerson J]

approximately $3,000 would be reasonable. She sought costs and publication of Mr White's name.

27. Mr Swanepoel acknowledged that it was difficult to argue for Mr White that name suppression should continue, but submitted that it was a decision for the Tribunal. He said that there were no additional factors for the Tribunal to consider than those raised in Mr White's affidavit of January 2013.

28. The estimate of costs for the PCC's investigation and prosecution is $25,221. The Tribunal's estimate of costs is $16,900. These costs amount to approximately $39,000 excluding GST. In addition, Ms Hughson sought costs.

Decision

29. The Tribunal announced its decision orally at the conclusion of the hearing. The Tribunal has had an opportunity of viewing exhibit 4 (the photographs taken by Mr White on the 16 December 2010 and not sent to the ophthalmologist following the referral in February 2011). The Tribunal is concerned about these because they show clear retinal detachment and are photographs of excellent quality. However in response to these photographs, there was no immediate recognition by Mr White (indeed no recognition at all) that he should make a diagnosis of retinal detachment or should refer Mr McGiven with urgency to an ophthalmologist. Further he did not challenge his own diagnosis made in the week before when he diagnosed "right sup defect and ambyopia". The Tribunal considers that the failure to make a diagnosis of retinal detachment and then not to refer that urgently for an ophthalmologist's opinion are significant departures from the standards to be expected of a reasonably competent optometrist. Indeed the Tribunal is concerned that these failures illustrate a lack of competence as an optometrist in Mr White. The delay in referral was serious and detrimental and well below the expected standard. It cannot be dismissed as an administrative error.

30. Bearing in mind the Tribunal's obligation to impose the least restrictive and punitive penalty on Mr White and the need to rehabilitate him, the Tribunal considers that the appropriate penalty is a penalty of suspension. The Tribunal

recognises that Mr White is not practising as an optometrist but nonetheless considers that this is the right penalty to impose given the seriousness of the conduct complained of, coupled with this Tribunal's recognition that he should be rehabilitated. Accordingly the Tribunal suspends Mr White from practice for a period of six months.

31. Once Mr White resumes practice, the Tribunal imposes conditions upon Mr White's practice:

(a) That Mr White be required to practise under supervision for a period of 18 months by a Board appointed supervisor with the parameters of the supervision (including as to where the supervision would be carried out) to be at the discretion of the Board. The cost of the supervision is to be met by Mr White;

(b) Mr White is required to satisfy the Board that he can demonstrate competence in fundamental eye assessments, examinations and diagnostics. The costs of any required assessment by the Board in this regard are to be met by Mr White; and

(c) Mr White is not to practise as a sole practitioner for a period of three years from the date of this order.

32. The Tribunal does not impose any fine against Mr White in recognition of the fact that it has suspended him from practice and his solicitor's advice that he is of limited financial means.

33. The Tribunal orders that Mr White pay costs in the sum of $10,000 representing approximately 25% of the costs of the Tribunal, the prosecution and the investigation. The Tribunal considers it appropriate that Mr White contribute to these costs and they not fall solely on the profession but that he should also be entitled to a discount given the fact of his guilty plea and an agreed statement of facts.

34. The Tribunal suspends orders set out in paragraph 31 above for a period of two weeks from the date of the oral decision to allow Mr Swanepoel to take instructions as to whether his client wishes to appeal.

Interim Name Suppression

35. The Tribunal has considered the order for interim name suppression currently in place. The PCC sought the lifting of the interim order and Mr Swanepoel did not advance any further reasons why the Tribunal should continue the order.

36. Given that Mr White has pleaded guilty to the charge, the Tribunal no longer considers that his personal interests should outweigh those of the public in knowing the name of the optometrist charged and the details of the offence to which he has pleaded guilty. Accordingly, the Tribunal also discharges the interim order relating to name suppression but again this order is not to come into effect for a period of two weeks from the date of the oral decision, in order to give Mr Swanepoel time to appeal, if that is his client's decision.

37. The Tribunal directs the Executive Officer to publish a copy of this decision and a summary on the Tribunal's website. The Tribunal further directs the Executive Officer to publish a notice stating the effect of the Tribunal's decision in the Optometrist and Dispensing Opticians' Board newsletter and the New Zealand Optics monthly magazine "New Zealand Optics".(Section 157 HPCA Act 2003).

DATED at Auckland this 8th day of April 2013

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K G Davenport
Deputy Chair
Health Practitioners Disciplinary Tribunal