

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

GENERAL OPTICAL COUNCIL

F(22)37

AND

MANISH PATEL (01-21846)

**SUBSTANTIVE DETERMINATION
IMPAIRMENT
16 May 2023 – 31 MAY 2023**

Committee Members:	Mr Graham White (Chair/Lay) Mr Kevin Connolly (Lay) Mr John Vaughan (Lay) Mr Christian Dutton (Optometrist) Ms Gemma O'Rourke (Optometrist)
Legal adviser:	Dr Austin Stoton
GOC Presenting Officer:	Ms Wafa Shah
Registrant present/represented:	Yes present and represented
Registrant representative:	Mr David Claxton (Counsel) Ms Katharine Germishuys (AOP)
Hearings Officer:	Mr Lee Wood days 1 – 3 Ms Nazia Khanom 4 - 8 Mr Lee Wood days 9 – 10
Application to amend: Submission of no case to answer	Allowed Allowed
Allegations proven	1 b (i), 1 b (ii)
Allegations not proven	1 a (i), 1 a (ii), 1 b (iii)
Misconduct	Found
Impairment	Not found
Warning	12 Months

ALLEGATION (as originally settled)

The Council alleges that you, Manish Patel (01-21846), a registered optometrist:

1. On or around 14 April 2020, you conducted a sight test on Patient A and you:
 - a. failed to conduct an appropriate assessment of Patient's eyes in that you;
 - (i) failed to detect signs of a choroidal melanoma with associated retinal detachment in the Patient A's right eye;
 - (ii) incorrectly detected a posterior vitreous detachment in Patient A's right eye, failed to carry out an adequate sight test on Patient A's right ocular fundus despite this being clinically indicated.
 - b. failed to carry out an adequate sight test on Patient A's eyes in that you;
 - (i) did not undertake an adequate examination of Patient A's right ocular fundus despite this being clinically indicated;
 - (ii) did not detect and/or did not document the presence of a pigmented lesion in the right eye;
 - (iii) failed to urgently refer Patient A to the hospital eye service for further investigation of the signs of a choroidal melanoma with associated retinal detachment;

And by virtue of the facts set out above, your fitness to practise is impaired by reason of misconduct.

Determination of the Council's application to amend the head of allegation 1, allegation 1 a (ii) and 1 b

The Council applied under Rule 46 (Order of Proceedings) paragraph 20 to amend the head of allegation 1, allegation 1 a (ii) and 1 b to properly reflect the circumstances of patient A's eye examination, as opposed to a sight test.

The Committee carefully considered the submissions of both the Council and of the Registrant. The application was agreed by the Registrant. The Committee accepted the advice of the legal advisor. The Committee concluded that acceding to the application was in the interest of justice.

The Committee did not find that acceding to the application prejudiced Mr. Patel. The evidence relied on by the Council had not altered and the thrust of the Council's case had not changed. The Committee further considered that the amended allegations adequately covered the extent of the breaches advanced by the Council and the application was not opposed. The Committee gave leave for the amendments to be made.

The allegation as amended therefore read:



ALLEGATION (as amended)

1. *On or around 14 April 2020, you conducted an eye examination on Patient A and you:*
 - a. *failed to conduct an appropriate assessment of Patient's eyes in that you;*
 - (i) *failed to detect signs of a choroidal melanoma with associated retinal detachment in the Patient A's right eye;*
 - (ii) *incorrectly detected a posterior vitreous detachment in Patient A's right eye;*
 - b. *failed to carry out an adequate examination on Patient A's eyes in that you;*
 - (i) *did not undertake an adequate examination of Patient A's right ocular fundus despite this being clinically indicated;*
 - (ii) *did not detect and/or did not document the presence of a pigmented lesion in the right eye;*
 - (iii) *failed to urgently refer Patient A to the hospital eye service for further investigation of the signs of a choroidal melanoma with associated retinal detachment;*

And by virtue of the facts set out above, your fitness to practise is impaired by reason of misconduct.

Background to the allegations

On 24th May 2018 Patient A attended an Acute Primary Care Ophthalmology Service (APCOS) appointment with the Registrant, apparently having had dry eye symptoms following an episode of conjunctivitis managed through her GP. Patient A was found to have dry eye and was discharged from the service. Approximately 3 weeks later Patient A reattended APCOS on 14th June 2018, with a two-week history of irritable eyes, an episode the Registrant considered was due to allergic conjunctivitis. Patient

A was discharged. Subsequently, Patient A attended REDACTED in Maidstone, Kent on 18th August 2018 for her routine eye examination when she was examined by REDACTED. REDACTED made a referral dated 21st August 2018 for a routine ophthalmology consultation on account of Patient A being new to the practice, and their finding of a naevus in the right eye,

“which appears distinct, flat scattered diffuse drusen present on naevus, located nasal disc appears 2/3 DD in size. Please see routinely for a routine check with ophthalmologists as Px has never had this checked before.”

Thereafter Patient A was triaged to attend a ‘community ophthalmology team’ appointment and she was examined by an optometrist, REDACTED, on 17th September 2018 at REDACTED. At this appointment REDACTED notes included a fundus photograph and noted a “naevus” in Patient A’s right eye. There is a sketch in the contemporaneous records which indicate the presence of a circular hyperpigmented area with the adjacent notation: “flat naevus?”, REDACTED decided to monitor the condition 6 months later.

REDACTED wrote to the medical centre and REDACTED on the 20th September 2018 stating:

(Patient A) was referred to my Community Ophthalmology Team clinic by her own optician as they had noticed a naevus on her right retina. On examination there is an area of right hyperpigmentation with familial drusen. It's flat with no surface lid and it doesn't appear to be a naevus, however I am going to see (Patient A) again in 6 months' time for a review to ensure it isn't changing.

Before her next appointment with REDACTED, Patient A appears to have reattended REDACTED for a regular appointment with REDACTED on 15th December 2018. Thereafter, Patient A duly reattended the community ophthalmology team appointment on 25th March 2019 with REDACTED, where a fundus photograph was taken. She considered the lesion to be unchanged and arranged for a further 6-month review. A third visit to REDACTED was booked for 16th September 2019. In the contemporaneous records she recorded the presence of retinal hyperpigmentation and a naevus. On that occasion, a fundus photograph was not

taken and, having decided the lesion remained unchanged, REDACTED discharged Patient A from the service.

Approximately 7 months later, Patient A had been experiencing symptoms of an 'aura' in the right eye, along with blurring/twinkling in her right eye visual field. On the 14th April 2020 she contacted her GP who referred her the same day with a suspected PVD to the acute service (APCOS). The GP sought "*Confirmation of diagnosis, rule out more serious pathology, advice to patient*"; Patient A was examined by the Registrant that day.

The Registrant noted the reason for the visit to be "*Px referred by her GP for the investigation of suspected PVD. Px reports flashes & floaters since 1 month ago after a fall & head injury.*" He also noted that Patient A had dry eyes and a right eye naevus in the history and symptoms section of his record. On examination he noted the presence of a posterior vitreous detachment (PVD) in the right eye. He further records that the macula was: "*Healthy, Flat & clear*" in both eyes and that the fundal periphery was: "*Flat c no obvious retinal tears or detachments*" in both eyes.

In a letter to the general practitioner the Registrant wrote:

"(Patient A) attended my APCOS clinic, at your request, for investigation of flashes & floaters symptoms on the right side. She reports flashes after experiencing a fall with a head injury one month earlier.

Dilated fundal examination revealed no obvious retinal tears or detachments on either side but did confirm the presence of a posterior vitreous detachment on the right side. VA is good on both sides.

I have provided flashes & floaters advice and have advised (Patient A) to return immediately if symptoms change or worsen. No other treatment is required at this time and I am happy to discharge".

Over the next few months, Patient A felt her eyesight was becoming more distorted, and on 27th July 2020 she reattended REDACTED complaining of flashing lights and visual disturbance. She was examined by REDACTED who suspected a right eye melanoma with retinal detachment. In the records section is an entry which reads: "*Peripheral retina: R RAISED -FLUID PRESENT -POSS*

MELANOMA/RD". The optometrist wrote an urgent referral letter to Patient A's general practitioner noting the presence of a raised retina in the right eye with fluid present.

Patient A was seen in the Ophthalmology Department at Maidstone Hospital on 4th August 2020 where her visual acuities were noted to be 6/12 in the right eye and 6/5 in the left eye. She was diagnosed with a *macula on retinal detachment* in the right eye and referred to the Vitreoretinal Clinic at St Thomas' Hospital.

Patient A was seen in the vitreoretinal clinic at St Thomas' Hospital on 5th August 2020 where she was noted to have: "*A large nasal melanoma with SRF* (sub retinal fluid).

Patient A was then referred to the Ocular Oncology Service at Moorfields Eye Hospital where she was seen on 11th August 2020. On examination her visual acuities were noted to be 6/18 in the right eye and 6/6-2 in the left eye. She was noted to have a five month history of symptoms in the right eye which were flashing lights and a gradual blurring of vision. There was a sketch in the contemporaneous record which indicated the presence of a bilobed pigmented tumour nasal to the right optic disc with an extensive inferior retinal detachment which included the fovea. A diagnosis of a large choroidal melanoma with an extensive retinal detachment was made.

Patient A underwent an ocular ultrasound of the right eye which demonstrated the presence of a large bilobed tumour with an associated retinal detachment. The tumour dimensions were recorded as: "Transverse base: 23.4 mm Longitudinal base: 17 mm Elevation 7.1 mm". Patient A underwent a right eye enucleation (removal) in September 2020. Patient A states she was informed that the ocular tumour would have been present for at least a year. Patient A complained to the GOC on 11th November 2020, feeling let down by the profession.

Submission of no case to answer

At the close of the Council's case Mr. Claxton made a submission of no case to answer in respect of allegation 1 a (ii), namely that the Registrant had "*incorrectly detected a posterior vitreous detachment in Patient A's right eye*". As the Committee observed, that submission was commendably short. It is set out in full below:

1. *It is submitted that there is no case to answer in respect of charge 1 a ii. This alleges that Mr Patel 'incorrectly detected a posterior vitreous detachment in Patient A's right eye. 'The meaning and effect of the wording of this is clear: namely that there was no posterior vitreous detachment (PVD). There is:*
 - i. *no evidence before the Committee as to the state of Patient A's vitreous area;*
 - ii. *no evidence from which a reasonable inference as to the state of Patient A's vitreous area may be drawn.*
2. *There is evidence that:*
 - i. *PVD is a common condition;*
 - ii. *PVD usually affects those over the age of 60 (Patient A was born in REDACTED);*
 - iii. *PVD is a condition that can co-exist with other ocular conditions, such as dry eyes or ocular melanoma.*
3. *The clinical records in the Council's bundle do not speak to the condition of Patient A's vitreous. Professor Harper clarified that his paragraph 5.3.3. in which he opined that the clinical finding of a PVD was inappropriate should not be taken to mean that there was no PVD, rather his emphasis was on the fact that if a suspicious lesion was detectable (and in his opinion it was) that should have been the primary focus of Mr Patel's attention, not a comparatively benign co-morbidity. To the same effect, Professor Rennie confirmed in cross-examination that he did not suggest that Patient A did not have PVD or that Mr Patel's diagnosis of this condition was in any way wrong.*
4. *In the above circumstances, the test in limb one of R v Galbraith is satisfied: that is, there is no evidence that detecting a PVD was incorrect.*

Mr. Claxton's oral submissions emphasised that the application was put under the first limb of *Galbraith*.

Ms. Shah candidly, and properly in the Committee's judgment, summarised the expert evidence as neither Professor Harper and Professor Rennie having stated that it was not incorrect to have detected a PVD.

The Committee accepted the advice of the legal advisor.

The Committee determined that neither expert had suggested that there was no PVD, and that there is a deficit of evidence that would have allowed the Committee to arrive at the conclusion that there was no PVD. There is, however, evidence that does support the existence of a PVD at the time of the Registrant's examination of Patient A. The reason for the referral by the GP, as stated in the referral form was suspected posterior vitreous detachment. The Registrant's own record of the clinical assessments and findings he conducted on the 14th April 2020 and the expert evidence about the overlap of symptoms between a PVD and a retinal detachment supports the conclusion of the existence of a PVD being present at the time.

The Committee therefore accedes to the Registrant's application of no case to answer in respect of allegation 1 a (ii) and dismisses that allegation.

Ms. Shah suggested that the true mischief that the allegation sought to address was not that the PVD diagnosis was incorrect but that that diagnosis was inappropriate in the light of more serious pathology. The Committee considered the Council's suggestion that the Committee has power to vary an allegation of its own volition, although she stopped short of positively advancing that application. The Committee observed that such an application would have been improper. It is for the Council to properly particularise the allegations faced by a Registrant, and that they are under a duty to do so in good time. The Committee further considered that such a late amendment to an allegation would have caused the Registrant prejudice and would have necessitated the recalling of evidence. In any event, the Committee did not consider that the suggested allegation made any difference to the nature or seriousness of the allegations faced by the Registrant.

Findings of Fact

The Committee received evidence from Patient A and from two expert witnesses Professor Harper (an Optometrist Consultant) and Professor Rennie (a Consultant Ophthalmologist specialising in Ocular Oncology). The Registrant also gave evidence. The Committee heard submissions from both Ms. Shah and Mr. Claxton. The Committee carefully considered all the evidence and the submissions of counsel. The Committee received and accepted the advice of the legal advisor on the burden and standard of proof, the standard to which a practising optometrist should be assessed, expert evidence and the Registrant's good character.

Allegation 1 a (i)

1. ***On or around 14 April 2020, you conducted an eye examination on Patient A and you:***
 - a. ***failed to conduct an appropriate assessment of Patient's eyes in that you;***
 - (i) ***failed to detect signs of a choroidal melanoma with associated retinal detachment in the Patient A's right eye;***

The Registrant conducted an eye examination of Patient A on the 14th April 2020. The referral from the GP specifically mentioned a suspected PVD in the right eye and asked the Registrant to rule out more serious pathology. The Committee considered that those instructions were sufficient to have prompted the Registrant to undertake a thorough assessment of Patient A's right eye. In light of the referral it appears that the Registrant concentrated his assessment on establishing the presence of a PVD, retinal tear and retinal detachment at the time of the examination. However, the Committee considered that the Registrant should have also considered and notes other causes of the presenting symptoms.

Professor Harper stated that a reasonably detailed, problem-oriented assessment was conducted by the Registrant, including pupil dilation. He also acknowledged

that the examination took place during the unprecedented circumstances of the first COVID-19 lockdown where routine sight testing had been suspended. He further stated that by providing an acute community service, the Registrant “*stepped up to the plate*” despite various restrictions being placed on assessments, including reduced contact time with patients. Professor Harper considered that the Registrant conducted all the relevant tests and examinations that could have been reasonably expected at the material time. He did not consider the omission of fundus photography (as noted by Patient A in her complaint) to be unreasonable in circumstances where a dilated fundus examination had been undertaken. The Registrant explained that there was guidance from the local hospital that he was not to use fundus photography, automated visual field testing and Optical Coherence Tomography (OCT) imaging, due to adaptations of normal practice because of COVID - 19.

Professor Rennie was of the opinion that it is extremely likely a choroidal melanoma was present on the 14th April 2020. In oral evidence, he stated that it would have been elevated, of a significant size and detectable at the time of the Registrant’s examination. The Professor considered that, given that on 11th August 2020 Moorfields Eye Hospital diagnosed and measured the tumour to be 23 mm, which he stated was “*extremely large*”, it is highly unlikely that the growth would have occurred solely between the 14th April 2020 and the 11th August 2020. He further stated that having seen over 2000 choroidal melanomas, he had never seen one change from flat to 23mm in four to five months and therefore opined that the melanoma must have been of significant size on the 14th April 2020. The Committee accepts that evidence. The Committee noted that the REDACTED 27th July 2020 fundus photograph is consistent with a malignant melanoma of the choroid on that date, as stated by Professor Rennie.

Professor Harper was of the opinion that on the balance of probabilities, a concerning, raised, pigmented chorioretinal lesion was “*almost certainly visible*” in the nasal retina of the right eye at the time of the Registrant’s examination, consistent with the subsequent diagnosis of choroidal melanoma with retinal detachment. Professor Harper considered that it was very unlikely that the lesion was flat at the time of the Registrant’s examination. He considered that the lesion

would have been observable and visible due to its central location, although it would not have been as extreme a presentation as that photographed by REDACTED on 27th July 2020. Professor Harper also considered that Patient A's malignancy would almost certainly have been present approximately 15 weeks prior to the referral [on the 14th April 2020] from REDACTED to the hospital. He stated that it would have been inconceivable that there would not have been evidence of a frank and suspicious chorioretinal lesion in Patient A's right eye on 14th April 2020. It was his view that the Registrant had almost certainly missed a large suspicious lesion that he ought to have detected, requiring an urgent referral of Patient A. Comparing the fundus photographs taken on 17th September 2018 and 25th March 2019 at REDACTED, Professor Harper stated that there was the suspicion of change.

Professor Rennie considered that a choroidal melanoma was probably already present in March 2019 as there was some evidence to suggest that it was more likely than not that growth had already occurred by the 25th March 2019. Both experts noted that neither photograph captured the entire lesion. Professor Rennie indicated that malignant changes may have also occurred outside the central fundal area captured by fundus photography.

Both experts acknowledged that it was difficult to be confident that a retinal detachment would have been clinically detectable on 14th April 2020 without using additional scanning equipment (such as OCT). Both experts also acknowledged that the tumour was the most important feature to detect in this case. Professor Rennie was of the opinion that there was "*probably some degree of retinal detachment present*" although in his oral evidence he confirmed that he "can't say how much". He did say that he felt this would have been visible and detectable on the balance of probabilities at that time with a 90 Dioptre lens.

The indirect evidence, based on Patient A's symptoms of aura, rippling and shadow suggest a retinal disturbance caused by the underlying tumour or a retinal detachment, which Professor Rennie considered implied that growth had occurred, and thereby implied a raised mass would have been present at the time of the examination. Patient A's symptoms around the edge of her vision suggested the retinal detachment or elevation was more peripheral indicating the lesion was quite large. Professor Rennie said that those symptoms were not pathognomic of a

choroidal melanoma but are not indicative of a PVD. The Committee therefore concludes that further examination was clinically indicated beyond the Registrant's diagnosis of a PVD.

Professor Harper was of the opinion that it is more likely than not an evolving retinal detachment was present, associated with the lesion. Although the symptoms of a PVD and retinal detachment may overlap, Professor Harper suggested that Patient A's symptoms indicated a retinal detachment rather than "*merely a PVD*", specifically because of the visual field disturbance, blurring in right upper and lateral field (which coincides with the location of the lesion), loss of vision and progressive symptoms involving a larger area. Professor Harper felt that a reasonably competent optometrist would have "*detected a retinal and/or choroidal lesion at the back of the right eye*" on 14th April 2020 rather than be expected to try to "*tease apart*" an elevated pigmented lesion from a secondary retinal detachment. He stressed that an examination of the eye (particularly the retina and vitreous) was necessary to distinguish between a PVD and retinal detachment, rather than relying on the symptoms alone.

As concluded by both experts, the Committee was satisfied on the balance of probabilities that there was a choroidal melanoma present on the 14th April 2020. The experts also concluded that it is more likely than not that there was a co-existing retinal detachment but were unable to provide a definitive indication of its signs or detectability at that time.

The Committee is satisfied that the Registrant should have but did not detect signs of a choroidal melanoma. However, the Committee determined that there was insufficient evidence to establish that there was a clinically detectable retinal detachment associated with the choroidal melanoma on the 14th April 2020.

In oral evidence Professor Harper considered the Registrant's assessment of Patient A on 14th April 2020 to be reasonable including "*a reasonably detailed problem oriented assessment*". Professor Rennie agreed that the "*right practice was adopted*" by dilating Patient A's pupil and using a slit lamp with an indirect lens.

The Committee was cognisant of the COVID 19 restrictions, the general practitioner's focused referral on PVD and the Registrant's focus on excluding retinal tear/ detachment and his discharge of Patient A with appropriate clinical advice to contact him in the event that her symptoms worsened.

Having considered the conjunctive framing of allegation 1 a (i), namely, *choroidal melanoma with associated retinal detachment*, the Committee determined it was not possible to find that the Registrant's assessment was not an 'appropriate assessment'. The Committee therefore finds allegation 1 a (i) not proven.

Allegation 1 b (i)

- 1. On or around 14 April 2020, you conducted an eye examination on Patient A and you:**
 - b. failed to carry out an adequate examination on Patient A's eyes in that you;**
 - (i) did not undertake an adequate examination of Patient A's right ocular fundus despite this being clinically indicated;**

Professor Harper considered that the examination of Patient A's right eye was "*entirely inadequate*" because the Registrant did not detect and document the acutely presenting, significant and concerning chorioretinal lesion. He felt this was a "*very serious failing which therefore fell far below the standard expected.*" Professor Rennie reached a similar conclusion. In his opinion, an adequate examination would have been sufficient to detect the tumour, especially given its location and probable size. He would have expected an extensive examination of the whole retina to look for signs associated with a PVD, such as a retinal tear or detachment. As the lesion, which would have been visible, was not detected, the examination was inadequate.

The Committee noted that the Registrant recorded that Patient A's retina was healthy, flat and clear with no obvious tears or retinal detachments. The Committee considered this to be strong evidence of an inadequate examination and finds, consistent with the expert's opinions, that the Registrant failed to detect the suspicious pigmented lesion.

In his own statement, the Registrant agreed with Professor Harper's evidence in the following terms:

44. *I agree with Professor Harper at paragraph 5.1.3 and 5.1.4 that there is no doubt that Patient A had a large lesion next to the right optic nerve and that it had changed appearance significantly by 27 July 2020. The only evidence we have is the photograph of 25 March 2019 and then the photograph of 27 July 2020, but there is no doubt that between these dates the lesion changed significantly.*

At 5.2.7 of Professor Harper's report, he opined that:

It is inconceivable, in my view, that there would not have been evidence of a frank and suspicious chorioretinal lesion in Patient A's right eye on 14th April 2020. In my view, the Registrant has almost certainly missed a large suspicious lesion that he ought to have detected and resulted in an urgent referral for Patient A at the material time. His examination cannot therefore be regarded as adequate, including any mitigation within the context of the coronavirus pandemic.

In the Registrant's record of the examination under the section entitled Ocular Health (*Volk Examination*), he made no sketch of or reference to a pigmented chorioretinal lesion or raised mass. The Registrant recorded Patient A's retina as being flat after the pupil had been dilated. The Committee therefore concluded that there had been an inadequate examination which failed to detect the pigmented lesion in the right eye.

The Committee finds Allegation 1 b (i) proven.

Allegation 1 b (ii)

1. ***On or around 14 April 2020, you conducted an eye examination on Patient A and you:***
 - b. ***failed to carry out an adequate examination on Patient A's eyes in that you;***
 - ii. ***did not detect and/or did not document the presence of a pigmented lesion in the right eye;***

The Committee accepts Professor Rennie's opinion that a tumour *with a diameter of 23mm is so large that no other treatment other than enucleation was possible*, which suggests that it is unlikely that the malignancy grew exponentially during the 15 weeks prior to the diagnosis at Moorfields on the 11th August 2020.

In the Registrant's statement he said at paragraph 47 *"I further agree with Professor Harper at paragraph 5.2.6 that I did not document what was at least a large lesion."*

In the Registrant's statement he said at paragraph 51 *"I further deny that there was a retinal detachment on 14 April 2020, however I do admit that I failed to detect signs of a choroidal melanoma."*

At Paragraph 54 of his statement, the Registrant stated that *"I deny that I failed to detect the presence of the pigmented lesion, however, I admit that I failed to record it."*

The Committee accepted the Registrant's evidence that he experienced practical challenges carrying out patient examinations during the pandemic. Nevertheless, the Committee considers that an adequate examination of a patient is of paramount importance. The Committee does not consider that practical difficulties could justify an inadequate examination, notwithstanding the challenges experienced at the time. In the event that the Registrant considered that he was unable to conduct an adequate examination he should have recorded that and taken further appropriate action.

Professor Rennie was of the opinion that it is extremely likely that a choroidal melanoma was present on the 14th April 2020. In oral evidence he stated that it would have been elevated, of a significant size and detectable at the time of the Registrant's examination. Professor Harper was of the opinion that on the balance of probabilities, a concerning raised, pigmented chorioretinal lesion was present in the nasal retina of the right eye. He considered that the lesion would have been observable and visible due to its central location. Professor Harper also considered that Patient A's malignancy would almost certainly have been present

approximately 15 weeks prior to the referral by REDACTED in July 2020. He stated that it would have been inconceivable that there would not have been evidence of a frank and suspicious chorioretinal lesion in Patient A's right eye on 14th April 2020. It was Professor Harper's view that the Registrant had almost certainly missed a large suspicious lesion that he ought to have detected.

The Committee accepts the expert evidence and finds that the Registrant failed to detect the suspicious pigmented lesion in the right eye and as a consequence did not document it.

The Committee accordingly finds that Allegation 1 b (ii) proven.

Allegation 1 b (iii)

- (i) *failed to urgently refer Patient A to the hospital eye service for further investigation of the signs of a choroidal melanoma with associated retinal detachment;*

This allegation is contingent upon allegation 1 a (i). As the Committee has determined that allegation 1 a (i) is not proven, it follows inexorably that 1 b (iii) is not proven.

Misconduct

Having found the facts alleged in 1 b (i) and 1 b (ii) proven the Committee moved on to consider whether those facts amounted to misconduct.

The Committee received submissions from the GOC. Ms. Shah submitted that the failure to identify the lesion was sufficiently serious to amount to misconduct, notwithstanding that it was a single omission. On behalf of the Registrant, Mr. Claxton submitted that the omission was an isolated and self-contained event whilst working in the unprecedented circumstances of the first weeks of the COVID – 19 pandemic in an otherwise unblemished 20 year career by a diligent practitioner. The Committee accepted the legal advisor's advice on misconduct.

On the 14th April 2020 Patient A's GP referred her to the Registrant with a suspected PVD. The GP referral sought "*Confirmation of diagnosis, rule out more serious pathology, advice to patient*". Patient A was examined by the Registrant that same day. The Committee has concluded that the Registrant was prompted by the referral to rule out more serious pathology, and, notwithstanding that prompting, did not identify the existence of a suspicious pigmented lesion, the appearance of which was indicative of a choroidal melanoma.

Professor Harper considered that the examination of Patient A's right eye was "*entirely inadequate*" because the Registrant did not detect and document the acutely presenting, significant and concerning chorioretinal lesion. He felt this was a "*very serious failing which therefore fell far below the standard expected.*" Professor Rennie reached a similar conclusion. In Professor Rennie's opinion, an adequate examination would have been sufficient to detect the tumour, especially given its location and probable size. He would have expected an extensive examination of the whole retina to look for signs associated with a PVD, such as a retinal tear or detachment. As the lesion, which would have been visible, was not detected, he concluded that the examination was inadequate.

At 5.2.7 of his report Professor Harper reiterated "*that the Registrant has almost certainly missed a large suspicious lesion*". He regarded the Registrant's failure to detect Patient A's chorioretinal lesion in April 2020 as a serious failing, and one falling far below the standard expected of a reasonably competent optometrist. The Committee accepts the experts' assessment of the gravamen of the Registrant's failure.

The Committee had regard to GOC standard 7.1 which provides for the requirement to, *conduct an adequate assessment for the purposes of the optical consultation*. The Committee finds that this standard was breached insofar as the lesion was not detected.

The Committee had further regard to GOC standard 8.1 namely the requirement to *Maintain clear, legible and contemporaneous patient records which are accessible for all those involved in the patient's care*. The Registrant did not document that he

had observed a large lesion. The Committee finds that this omission was in breach of standard 8.1.

The Committee is satisfied that the Registrant should have, but did not, detect signs of a large pigmented lesion which was in keeping with a choroidal melanoma. By virtue of its probable large size and central location, it ought to have been readily detectable by the Registrant. The Committee considers that his failure to do so was both fundamental and serious.

In Professor Rennie's opinion, on the balance of probabilities, the delay in the eventual date of diagnosis would not have had any effect on Patient A's ultimate management and prognosis. However, the Committee was mindful of the serious sight-threatening and potentially life-threatening nature of a choroidal melanoma, and the life-changing effect it had on Patient A in view of the subsequent removal of her right eye.

Having considered all of the facts, the Committee concluded that the Registrant's omission was a single isolated negligent incident: However, it was of sufficient magnitude and gravamen to cross the misconduct threshold.

Impairment

The Committee received written and oral submissions from Ms. Shah and from Mr Claxton.

Ms. Shah submitted that the Registrant's fitness to practise was impaired by virtue of him:

- a. Having acted in the past and/or is liable to act so as to put a patient or patients at unwarranted risk of harm; and or
- b. Has in the past brought and/or is liable in the future to bring the optometry profession into disrepute; and/or
- c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.

The Council took the view that the Registrant had not shown sufficient insight to have remedied his conduct.

Mr. Claxton reminded the Committee that this case was a single incident, involving one patient on a single occasion and that as such the Committee ought to be principally concerned with any risk of repetition. He further submitted that there was a wealth of evidence as to the Registrant's competence and CET, the remediation he has undertaken and the extent of his general professional standing.

The Committee received advice from the legal advisor as to the approach to be taken regarding impairment. The Committee accepted that advice.

The Committee found that this incident was a single, isolated, negligent incident by a practitioner with an otherwise unblemished 18 year professional career. Notwithstanding the narrow ambit of the misconduct, the Committee considered this case to be very serious.

The Committee bore in mind that the Registrant has no previous fitness to practise history and no ongoing matters, neither is there any suggestion that the Registrant has misconducted himself save for the present incident. The Committee noted that the Registrant had set himself a learning goal within the GOC's MyCET website to "*Improve my knowledge & understanding of ocular lesions and tumours*". In keeping with this, the Committee noted the completion of CET focussed on the assessment and management of chorioretinal lesions, a clinical placement with a Moorfields Eye Hospital consultant ophthalmologist specialising in ocular oncology, and attendance at an ocular oncology seminar.

The Committee acknowledged that the Registrant has incorporated and entrenched Moorfields Eye Hospital's evidence-based "*MOLES system for managing patients with choroidal naevi*" into his practice. In keeping with this, the Committee noted a particularly relevant case record submitted by the Registrant highlighting a patient with a history of a choroidal naevus, who, in its opinion, had their lesion appropriately identified, imaged and documented. The Committee concluded that the Registrant clearly demonstrated in oral evidence how he would

now identify, assess and manage a pigmented lesion in his practice including when his access to diagnostic equipment is limited.

During the impairment stage the Registrant gave compelling oral evidence in respect of his revised approach to note taking and exploration of previously recorded, yet unseen conditions, including seeking a second opinion where indicated. The Registrant also acknowledged the importance of good record keeping, recording relevant negative findings and noting any restrictions encountered during an examination.

The Committee was also cognisant that the Registrant has engaged generally in higher qualifications throughout his career. His enthusiasm and passion for optometry was self-evident when he gave evidence at the Impairment stage. The Committee has noted the focused remediation work that the Registrant has undertaken. Consequently, the Committee finds that the Registrant has remedied any clinical shortcomings to the extent that they were evident on the 14th April 2020. The Committee considers the likelihood of repetition to be extremely low and accordingly the Registrant does not represent a risk to the public. The Committee bore in mind that the allegations date to three years ago, throughout which time the Registrant has practised without restriction.

In terms of his on-going professional development, the Registrant gave evidence that he engages fully with his peers with whom he collectively undertakes peer discussion and consideration of different clinical cases. The Committee considered that to be a significant and substantial addition to his professional practice. The Registrant has not claimed CPD points for these 'peer review' activities, which he would have been entitled to do. This in the Committee's view, further highlights his genuine commitment to his clinical development and good practice, as supported by a range of fulsome and highly supportive testimonials from senior clinical optometrists and consultant ophthalmologists.

The Committee found that the Registrant was and continues to work in an environment conducive to learning and high professional standards, supported by a collaborative approach of clinicians with complimentary practices and ophthalmology

oversight as required. The effect of this learning and engagement is that the Registrant has gone beyond the normal standards of practice.

The Committee was therefore satisfied that a finding of current impairment, on the grounds that it was necessary for the purpose of protecting the public, was not required.

The Committee went onto consider the Council's submission that professional standards and public confidence in the profession would be undermined if a finding of impairment were not made, insofar as he has or will in the future either bring the profession into disrepute or will breach one of the fundamental tenets of the profession. The Committee did not consider that a fully informed reasonable member of the public would consider that the Registrant either represented a prospective risk or that he lacked insight. The Committee concluded that the Registrant has developed insight, has been candid in his evidence and had not himself sought to challenge the experts' opinions. Questioning an expert about the identification of a choroidal abnormality is a different and distinguishable point from suggesting an expert's opinion is incorrect. The Registrant has always accepted the existence of a chorioretinal lesion.

The Registrant's actions in treating patients at the time of the pandemic was laudable. Whilst following local guidelines he was practising with a limited availability of PPE, *ad hoc* safety equipment and precautions and without a full complement of diagnostic equipment. In so doing he had sacrificed his own personal health and had put himself at risk at a time of unprecedented national emergency. The Committee considers that had he had access to a full complement of equipment and had he been able to examine the patient under normal conditions it is highly unlikely this incident would have come about. The Committee concluded that in the event of any further exceptional circumstances the Registrant has demonstrated how, for example, he would now identify, assess and manage a pigmented lesion in his practice including if his access to diagnostic equipment was reduced.

Given the exceptional context of this examination, in all the circumstances the Committee decided, on balance, that a finding of current impairment was not required on public interest grounds alone. The Committee considered that a fair minded member of the public, properly informed, as to the salient facts of this case would not expect such a finding to be made.

Having considered all of the evidence and submissions, the Committee does not consider the Registrant to be currently impaired.

The Committee now moves onto the issue of whether a warning should be considered under s13F (5) Opticians Act 1989.

Warning

The Committee heard submissions from both parties with regard to whether or not a warning should be given.

Ms Shah submitted that a warning was entirely appropriate in this case because the Committee had concluded that the allegations found proved amounted to serious misconduct, but the threshold for a finding of impairment had not been met. A warning would allow the Registrant to continue without disruption to his practice, whilst marking the seriousness of the misconduct. She referred to the relevant part of the Council's Indicative Sanctions Guidance. She submitted that the warning should be for 12 months.

Mr Claxton on behalf of the Registrant did not accept that a warning was necessary in this case. He submitted that a warning would be a serious matter for the Registrant and emphasised that all the listed mitigating factors in paragraph 20.7 of the Council's Indicative Sanctions Guidance applied to the Registrant's case. However, if the Committee decided to issue a warning, Mr Claxton submitted that it should be for a period of no longer than 12 months.

The Committee heard and accepted the advice of the Legal Adviser, who referred to Section 13F(5) of the Opticians Act 1989 and to the relevant part of the Council's Indicative Sanctions Guidance.

The Committee carefully considered whether a warning was appropriate and necessary having considered the evidence and the submissions of the parties.

The Committee had regard to the following passages from the Council's Indicative Sanctions Guidance:

“20.6 Factors when a finding of no impairment has been made and a warning may be appropriate:

- a. A clear and specific breach of the Standards of Practice.*
- b. The particular conduct, behaviour, or performance approaches, but falls short of the threshold for current impairment.*
- c. Where the concerns are sufficiently serious that, if there were a repetition, they would likely result in a finding of impaired fitness to practise.*
- d. There is a need to record formally the particular concern(s).*

20.7 If the Committee are satisfied that the registrant's fitness to practise is not impaired, they can take account of a range of aggravating or mitigating factors to determine whether a warning is appropriate, having regard to the public interest as part of their considerations. These might include:

- a. Genuine expression of regret/apology;*
- b. Acting under duress;*
- c. Previous good history;*
- d. Appropriate rehabilitative/corrective steps have been taken; and*
- e. Relevant and appropriate references and testimonials.”*

The Committee considered the import of the factors in 20.6 and considered all of them to be engaged. Having carefully balanced all the mitigating factors set out under

20.7, the Committee concluded that these were outweighed by the seriousness of the Registrant's conduct and the potential risk to the patient.

The Committee was satisfied that a warning should be given in this case to indicate that the misconduct found proved represented a serious departure from the standards expected of its Registrants and should not be repeated. Further, a warning was required to highlight to the profession and to the public that conduct of the kind found proved in this case is unacceptable.

The Committee decided to give the Registrant a warning in the following terms:

“You must ensure that the cause of a patient’s presenting signs and symptoms are fully investigated and recorded. You must take all steps necessary to conduct an adequate examination and, if such an examination is not practicable, you must record the reason for this and ensure that appropriate further action is undertaken.


You are specifically reminded to adhere to the ‘Standards of Practice for Optometrists and Dispensing Opticians’, in particular:

Standard 7: Conduct appropriate assessments, examinations, treatments and referrals.

Standard 8: Maintain adequate patient records”

Having considered the principle of proportionality and having reconciled the seriousness of the case with its effect on the Registrant, the Committee determined that the duration of this warning will be for 12 months, expiring on 1st June 2024.

Chair of the Committee: Graham White

Signature 

Date: 31 May 2023

Registrant: Manish Patel

Signature Present Via MS Teams

Date: 31 May 2023



FURTHER INFORMATION
Transcript
A full transcript of the hearing will be made available for purchase 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).
Professional Standards Authority
<p>This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA 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 insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public.</p> <p>Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address).</p> <p>Further information about the PSA can be obtained from its website at www.professionalstandards.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 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.

