

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

**F(06)14
F(06)15**

GENERAL OPTICAL COUNCIL

AND

SASHA LOUISE MACKEN (01-15852)

AND

WILFRED HUGH PHILLIPS (01-7245)

**Tuesday, 22 May 2007
and
Wednesday, 23 May 2007**

**FITNESS TO PRACTISE SUBSTANTIVE HEARING:
SASHA LOUISE MACKEN & WILFRED HUGH PHILLIPS**

Tuesday, 22 May 2007

Fitness to Practise Committee: Ms Margaret Hallendorff (Lay Member) (Chair)
Mr Alan Baldwin (Lay Member)
Mrs Geraldine Huka (Lay Member)
Mr Stephen Reily (Optometrist)
Ms Catherine Viner (Optometrist)

Legal Adviser: Mr David Swinstead

Hearings Manager: Mr David Henley BEM

For the GOC: Mr Chris Alder

For the Registrants: Mr Ian Stern QC

[Proceedings commenced at 10.35 am]

Ms Hallendorff: Good morning. I am Margaret Hallendorff, a lay member of the Hearings Panel, and I have been elected by the Committee to chair today's hearing.

The Committee today is made up of two optometrists and three lay members. I shall ask the members of the Committee to introduce themselves and the capacity in which they sit. *[Introductions made]*

To my right is Mr Swinstead, the Committee's Legal Adviser, who will provide legal advice and assistance to the Committee, and ensure that the proceedings are conducted in accordance with the rules of procedure so as to arrive at a result which is fair and just. The Legal Adviser may accompany the Committee should it sit in private to deliberate.

In the event that any matter arises during the course of the Committee's deliberations upon which the Committee seeks advice, the parties will be invited to return to hear the matter which the Committee has raised and the advice to the Committee.

Where advice on any issue is not accepted by the Committee, this will be indicated in the course of its decision on that issue.

At the desk in front of the Committee to my left is the transcriber, Mr Charles Nisbet, who will be keeping an official record of all that is said today during the sessions of the hearing at which the parties are present. Next to the transcriber is Mr David Henley, the Hearings Manager, who will provide

administrative assistance to the Committee. The remaining persons sitting in the hearing room (rather than in the public areas) are members of the respective legal teams.

All parties are reminded that, where details of a patient are to be discussed, that patient has been allocated the letter "A" in the allegation, and the patient should only be referred to by that letter. Are there any applications at this stage?

Mr Alder: Madam, I propose in due course to make an application that the evidence of the patient in this case be placed before you in a written form. I propose to make that application in due course, but I am conscious that you may wish me to deal with that as a preliminary issue now before I open the case. I am entirely in your hands but I anticipated it coming at a later stage.

Mr Swinstead: I would advise that it should properly be taken at the point when that witness would otherwise give their evidence.

Mrs Hallendorff: Thank you. Before we start, Mr Nisbet tells me that the recording facilities in this room are quite difficult, so could you speak up very clearly so that the recordings can be made. Thank you. I shall ask Mr Henley if he would read out the allegations please.

Mr Henley: [*reads*] The Council alleges that the fitness to practise of Sasha Louise Macken (a registered optometrist) is impaired in that:

1. At an examination of Patient A, as identified in the schedule, on 21st September 2005, Ms Macken did not:

- i) perform a slit-lamp examination;
- ii) measure her intra-ocular pressures;
- iii) undertake ocular investigations to try to identify the cause of her symptoms;
- iv) determine an explanation for her presenting symptoms;
- v) examine the ocular structures of her eyes;
- vi) adequately assess her presenting symptoms;
- vii) complete an adequate record of the examination.

2. In Ms Macken's representation to the Council of 7 March 2006, she inaccurately interpreted Patient A's hospital medical notes with regard to the date of the onset of her symptoms.

3. In Ms Macken's representation, she referred to Patient A's previous records indicating minor corneal changes which is inaccurate.

AND by reason of the facts set out above, Ms Macken is guilty of deficient professional performance.

The Council alleges that the fitness to practise of Wilfred Hugh Phillips (a registered optometrist) is impaired in that:

1. At an examination of Patient A, as identified in the schedule, on 10 October 2005, Mr Phillips did not:

- i) perform a slit-lamp examination;
- ii) adequately identify an explanation for her presenting symptoms;
- iii) perform an examination of near visual acuity;
- iv) complete an adequate record of the examination.

2. In Mr Phillips's representation to the Council of 4 March 2006, he inaccurately interpreted Patient A's hospital records with regard to the date of the onset of her symptoms.

3. In Mr Phillips's representation, he referred to Patient A's previous records indicating minor corneal changes which is inaccurate.

AND by reason of the facts set out above, Mr Phillips is guilty of deficient professional performance.

Ms Hallendorff: Thank you. May we ask the registrant or his representative whether any particulars set out in the allegation are admitted?

Mr Stern: No, Madam.

Ms Hallendorff: Thank you. Presenting officer's opening statement – Mr Alder.

Mr Alder: Thank you. If I may ask, first, whether we could hand up to you the bundles which will be before you? I expect this may assist you, as I propose to refer to a number of the documents in my opening. I propose to hand the bundles up to the Committee, because I shall refer to a number of the records as I go through in my opening. In due course, if my application that you read the statement of the witness is successful, it may be an appropriate time at that point to stop and read the bundle. That is on the basis that my application is successful, so it may not be deemed to be appropriate for you to read her statement in the bundle at this stage just in case.

Mr Swinstead: Madam, I believe that is right.

Mr Alder: The allegations against both registrants have been read through very clearly. First, let me apologise for the number of papers in front of you. They are replicated but there is a separate bundle for Ms Macken and a bundle for Mr Phillips and, while the bulk of those documents such as patient records are the same, they will be distinct in the sense that Dr Harper and the response from the registrant are separate to each of those bundles. I am conscious that there may be lots of paperwork flying around but I just ask you for your indulgence with that.

The allegations against both optometrists is that their fitness to practise is impaired by reason of deficient professional performance. Both cases are

joined before you in this one hearing, but you will be asked in due course to consider the merits of both of the cases separately. The Council accepts willingly its burden to prove the factual basis of the allegations, and you must be sure that the facts are proven in due course when you will be asked to make that decision. The subsequent determinations you may be asked to make in respect of deficient professional performance and fitness to practise are a matter for your professional judgment.

As with all cases before you, these cases will involve careful consideration. There are a significant number of documents, hospital records and clinical information available to you. However, I suggest that the two cases are relatively straightforward and the timeframes of the testings, which the Council says should have been performed, fall within quite a short period of time. The Council's case, and as I anticipate the evidence to come out, is that the case involves basic and fundamental clinical practice and the maintaining of basic clinical management of the patient.

The Council's case is that neither of the optometrists, both responsible for the care of one patient, undertook sufficient management, and neither acted in the patient's best interests in concluding that it was not necessary to perform a number of examinations, and it was not necessary to provide an adequate explanation for her symptoms.

The patient, at the time of her examinations at Julian Davies Opticians, was 67 years of age. At the point when she was first examined by Mr Davies and thereafter by Ms Macken and Mr Phillips, she was working as a part-time radiographer, having retired from her full-time position from her sixtieth birthday, and her evidence, in due course, as I have said, I shall make application to read to you, and her witness statement is available for you. It is the opinion of her general practitioner, Dr Daniels, that she is not fit to stand before you as a witness, she has significant stress-related symptoms which, in his opinion, would be exacerbated by giving evidence before you in what would be, as you would imagine, a highly stressful environment.

This particular patient had worn spectacles for around 20 years at the point at which she first saw Mr Davies, and for approximately five or so years of that time she had worn varifocal lenses. She visited Julian Davies Opticians in Cardiff and had concerns that her vision appeared to have reduced, and she was concerned about her driving. She first attended there on 12 September 2005, and Mr Davies tested her sight and prescribed further varifocals for her. She confirms in her evidence that, during that examination, she explained to Mr Davies that she recalled her right eye was bad: the vision in the right eye was poorer than she felt it should have been.

She returned to the practice, collected her spectacles and, initially, found that the distance vision provided by the varifocals was good. They provided good distance vision for her but suddenly she recalls that one night she felt a shooting pain above her right eye. She recalls headaches which for her were an unusual symptom. She recalls, again from the evidence in her statement, that she persisted with these varifocal lenses but noted that her vision started

to become blurry. The pain and, to her evidence, blurry vision and headaches are themselves potential symptoms of a number of ocular conditions or abnormalities, which could have included glaucoma, with which this patient in November 2005 was subsequently diagnosed.

Dr Robert Harper, Consultant Optometrist at Manchester Royal Eye Hospital, has provided opinion that these symptoms are clear potential symptoms for ocular abnormalities which include glaucoma. This patient has symptoms which are unusual to her such as headaches and pain above her right eye. Therefore, she returns to Julian Davies Opticians. She is concerned about the visual disturbance, the apparently reduced distance vision in her right eye and, of course, that being the eye where the pain is focused.

She returns to the practice on 21 September 2005 where she is seen by Ms Macken. Madam, if I could ask you to turn with me to page 11 of the bundle in respect of Ms Macken's case, you will see there the record card of the examination. This is consistent with the evidence of the patient and you will see the record of the examination taken by Ms Macken. On the left-hand side where it says Symptoms and History, it says, as I understand it, "worn varifocals previously" and "distance vision reduced" – you will see an arrow indicating reduced. It also says in the Symptoms and History section, the abbreviation for headaches and these interpretations are not disputed. It shows headaches and pain right eye five minutes.

Madam, these records also suggest the advice, as the patient recalls, that she should continue with her varifocals and there was some form of adaptation problem with these spectacles. It states there very clearly on the bottom right-hand side: "return if problems, possible separates", which alludes to removing the patient from varifocal lenses to individual spectacles for near and visual tasks.

This is a patient who attended with specific symptoms, she went to the practice to have those symptoms examined and explored. She was told that she should persist with the varifocals. That summarises and reflects the background to the Council's case involving Ms Macken in respect of allegation 1. Patient A returned with specific concerns, she attended with what to her were unusual and worrying symptoms, which, in the opinion of Dr Harper, are indicative of an ocular problem, and are not sufficiently and adequately explained by there being an adaptation to spectacles problem. The Council's case is that additional examinations, as set out in the allegations, at that point should have been undertaken by Ms Macken. The Council say there should have been an examination using a slit-lamp. There should have been a measurement of the patient's intra-ocular pressures. There should have been an examination of the ocular structure of her eyes and further ocular investigations in order to assist her to provide an adequate explanation for the patient's presenting symptoms.

Ms Macken concluded that the patient was not adapting to, or tolerating, her varifocals, which, of course, were not new to her: she had been wearing varifocals for some years. However, the Council's case is that that was not

sufficient and that, while toleration may have been something for an optometrist to bear in mind, more should have been done, more tests should have been performed at that point. Given her symptoms, to have allowed for an adequate and full explanation to be given to the patient, that was determined and dictated by her interest as a patient, it was in her best interest to have had that full explanation.

It follows that the examination itself was, in the Council's submission, inadequate, the explanation for the symptoms, as is set out in the allegation, was not adequate and, as Dr Harper will explain, you will be entitled to conclude that the records she kept were also inadequate. In respect of the clinical practice of Ms Macken, that would be the Council's case before you but it does not end there, because the patient is told to persevere with her varifocals: forget the symptoms, carry on and you will soon tolerate these spectacles. She, therefore, persevered as, after all, she is a radiographer, she is aware of clinical opinions and takes on board the advice given to her by the clinician. She continues to try to wear the glasses but the pain above her right eye persists, the visual disturbance continues and the headaches continue. Finally, as perhaps you or I would do, if one continues to have these concerns, you then return to the practice and say to the optometrist the pain is still there, it has not gone away and I have been wearing the varifocals as I have been advised to.

This time she is seen by Mr Phillips, the second registrant who was responsible for the care of this patient. She, again, confirmed to him her symptoms. He has available to him at that examination not just the record card from Mr Davies but also the subsequent record from Ms Macken, which, as you have seen, records about the headaches and pain continuing since at least 21 September. She visits him on 10 October 2005 and there is no evidence to suggest that it was a prearranged appointment, and she had attended because of these continuing symptoms.

Mr Phillips performed a number of examinations on this patient, and his conclusions were, as those of Ms Macken, that this was a tolerance issue. However, there are some clear differences between the two conclusions that the optometrists have drawn. Mr Phillips concludes that she should not continue with the varifocals but to split her spectacle prescription between two pairs: one for distance work and one for near work. There is also a significant increase in the power of her near vision spectacles to that which had been initially prescribed by both Mr Davies and Ms Macken.

During this second examination, we know that he has been provided with the symptoms of pain and headaches continuing for some time. According to the records, there is no information provided that there was the performance of a slit-lamp examination and the results that that would have shown. There is also no record, and the Council's case is clearly put, that there was an examination of the near visual acuity of this patient. It would seem clear that when one is prescribing near vision spectacles with a changed prescription to the one provided by the previous optometrist, an examination of near visual acuity would provide you with what could be quite central information when

making that prescription. However, no test has been performed and no examination of the near visual acuity by Mr Phillips.

In not completing those additional examinations, as is again the Council's case as reflects that put against Ms Macken, it was not to act in the patient's best clinical interests. By not performing a slit-lamp examination, by not performing an examination of near visual acuity, it was not possible for the registrant Mr Phillips to have provided a full and adequate explanation for what were unusual symptoms. Dr Harper will tell you that the issue of pain isolated in one eye is unusual and, therefore, concluding that it is a spectacle tolerance issue is not a sufficient or adequate explanation.

Mr Phillips at this examination knew that the patient had been suffering pain above her right eye for some time, he knew she had headaches and that she had experienced reduced distance vision since 12 September 2005. We are now at 10 October and still the varifocals were not working and not dealing with the symptoms. The Council say that more should have been done in the patient's best interests, and a further explanation was demanded. Dr Harper is available, in due course, to provide his expert opinion, and his conclusions are that, given the specific symptoms which were part of the spectrum of symptoms of glaucoma and other ocular abnormalities, more should have been done. Also the explanation given by Mr Phillips just did not stack up. Given this patient's symptoms, the fact that he concluded that this was a spectacle intolerance problem was simply not sufficient and, perhaps colloquially speaking, does not make any sense, Madam. That is a matter for his expert opinion in due course.

To complete the picture for you, the patient's symptoms did not go away, they became increasingly worse and she presented at the University Hospital of Wales, Cardiff, complaining of a headache, a stabbing pain above her right eye, vision which had become blurred. The only different symptom with which she presented on 1 November was that she had a red eye, which itself is indicative of an acute attack of angle closure glaucoma, with which on that day she was indeed diagnosed.

Madam, there are two further allegations in respect of both optometrists, and you will be aware of those. In respect of both registrants in allegation 2, the representation of Mr Phillips and Ms Macken to the Council of 4 and 7 March 2006 "inaccurately interpreted Patient A's hospital records with regard to the date of the onset of her symptoms". When the Council receives notification of a concern from a member of the public or from a patient, it sends out to the registrant the information which it has available or the evidence which it has at that point - all copies of hospital records, all copies of patient records it may have - and asks the individual registrant for a response. It is the response which is the subject of both of these allegations.

The response provided by both optometrists is available for you and perhaps I could ask you to turn to page 51, remaining with the bundle of Ms Macken. In the subsequent page of that response in the third paragraph from the bottom – I only allude to Ms Macken's response because the same is reflected in that

of Mr Phillips – it states: “Having reviewed Patient A’s medical records, I note that on her visit to the Heath Hospital in Cardiff on 6 November 2005, she reports an onset of symptoms of only one week”. The conclusions drawn by Dr Harper and which thereafter reflect the Council’s concerns are that these particular statements do not accurately reflect the statements made in the hospital records. Madam, if I could ask you to turn with me to the record in the hospital notes in the same bundle available to you at page 22 – I refer to the central pagination on the page. [*Discussion regarding page numbers*]

This is a notation of the record kept of Patient A’s visit to the hospital with the date recorded at the top left-hand corner. It says half-way down “red right eye” and beneath that “HOL” it seems “onset 1/7 ago” beneath that, “previous episodes in past x3 (within 3/52) resolved spontaneously”. Madam, these are the symptoms with which the patient has presented to the hospital. You will recall from the response of both registrants that there was an onset of symptoms of only one week. The concern of the Council is that the symptoms with which she presented record the onset 1/7 ago, but also previously episodes within past x3 (within 3/52), which suggests that the symptoms from which she was suffering at that time and which she reported were recorded by her some three or so weeks previously and not the one week that is referred to in the response. It says beneath that “feels eyes became” – Madam, I can’t give evidence, I won’t interpret what I cannot read properly – “ever since having new glasses 3/52 ago”. There are clear suggestions in the symptoms that she has presented to the hospital that the onset of her symptoms was beyond one week.

Madam, that is how the Council puts its case and has put its case throughout. Furthermore, in respect of allegation 3 in the representation, there is a reference made to Patient A’s previous records indicating minor corneal changes. Again, Madam, the reference in Ms Macken’s bundle is at page 51 and, again, I shall not take you to Mr Phillips’s response because these matters are the same. It states there: “I reviewed Mr Davies’s notes which detail early lens changes and minor corneal changes Fuchs’ Dystrophy”. Dr Harper will give you more detailed evidence about this, Madam, but the Council’s case is clear that those records do not identify minor corneal changes.

The response from many may be so what? How important is that? Isn’t it just a minor error? However, Madam, I would suggest that this goes more fundamentally to the Council’s concerns in the case involving both of the registrants. You could assume the response which you provide to your professional regulatory body would take some time to construct. You would consider all of the records available to you and you would consider ensuring that that response was as accurate an interpretation of your recollection as it could be. However, what we have here are two very clear interpretation issues.

In the context of the case of Mr Phillips and Ms Macken, they go much deeper, I suggest, both in their response to the Council in that it is suggested they have reviewed the previous records available to them when examining

this patient and that, to some extent, those considerations of previous records have impacted upon their clinical management and decision-taking. The concern, therefore, is that if your interpretation of that previous clinical information, clinical data, patient records - call it what you will - is inaccurate, that affects your management of the patient. Not only is it not in the patient's best interests not to have interpreted the data correctly, but also, to some extent, it places the patient at risk if your decisions are based upon an examination undertaken by another optometrist, in this case almost a month earlier, when we speak to the particular case of Mr Phillips.

Therefore, Madam, the interpretation by a clinician of such information is central to their work and to the work of a reasonably competent optometrist. I use that term quite pointedly, because, at some point in this hearing, you will come across it and that is the test I suggest that you apply. It is the standards of the reasonably competent optometrist which form your marker as to whether, if you find the facts proven, the conduct of either of these registrants is said to be deficient in its professional performance.

Madam, that closes my somewhat lengthy opening statement but, as you will appreciate, we have some clinical evidence in this case and there are two cases before you. Unless I may assist you further, now would be my opportunity for the patient to provide her witness evidence.

Mr Swinstead: I should perhaps make clear to members of the Committee that you have referred to certain matters at the moment in opening but they are not evidence, and it will be evidence that you are seeking to put before the Committee. I should make that absolutely clear that anything you say in your opening is not evidence.

Mr Alder: It is merely opening.

Mr Swinstead: Exactly.

Ms Hallendorff: [*consults members of the Committee, no comments at this stage*]
Thank you, would you like to carry on.

Mr Alder: Thank you, Madam. The Council does not have available before you the patient who is obviously central to this case. She is, given the evidence of her general practitioner Dr Daniels, unfit to attend before you as a witness. There are two grounds on which I make the application before you. First, if, as a matter of the Criminal Justice Act and, by analogy, the Rules before you, this witness is unfit to attend, you are entitled to consider her evidence in its written form. Section 116 of the Criminal Justice Act 2003 provides that:

“In criminal proceedings” – and these are not criminal proceedings but, by analogy, the issues may be the same – “a statement not made in oral evidence in the proceedings is admissible as evidence of any matter stated if oral evidence given in the proceedings by the person who made the statement would be admissible as evidence of that matter”.

In this case, she is the patient, she would be able to provide oral evidence and that would be admissible. [*continues to quote from Act*]

“The person who made the statement (the relevant person) is identified to the court’s satisfaction”.

The patient has signed and affirmed the truth of a witness statement in which her name is set out and it clearly identifies her. The patient records identify that she is the person who is making the particular statement. Then you have the five conditions mentioned in subsection (2) being satisfied.

Madam, the condition on which I rely would be in a criminal court (2)(b) “that the relevant person is unfit to be a witness because of his bodily or mental condition”. This is the ground upon which I rely and I would like to hand up to you the medical evidence from the patient’s GP. [*Statements handed to members of the Committee - pause*]

The conclusions and opinion of Dr Daniels, the patient’s GP, are very clear. In his letter of 30 April 2007, he states:

“It is my opinion that Patient A is unfit to be a witness by virtue of her mental condition, exacerbated by the hearing or otherwise. I have no doubts that her ongoing symptoms will ease when the case has been concluded.”

He refers in some detail to the stress under which this patient finds herself and refers quite worryingly, I would suggest, to a previous chest pain, for which she attended hospital and which was almost certainly stress related.

It may, in your mind, Madam, be unclear why there are two letters. Initially, the first letter was said not to be adequate for the purposes of the Association of Optometrists and, therefore, two specific questions were put to Dr Daniels, first, to confirm that it was his opinion that this patient is unfit to attend as a witness or, if not, where his opinion had derived from. He very clearly writes in his letter of 18 May:

“I write this letter of clarification further to my last letter about the patient. It is my opinion that she is unfit to attend the hearing and my opinion is not based on any request or otherwise from Patient A to prevent her from attending the hearing.”

He refers to the patient having significant stress-related symptoms which would themselves be significantly affected by her attendance. He refers to her being admitted as an emergency to the University Hospital of Wales and gives a consistent description of her symptoms. Madam, that is the opinion of her GP and I have no involvement other than seeking his opinion in that opinion which he presents. That is quite clearly his view that she is unfit to appear before you as a witness. I hope I have referred to the significant effect that these matters would have on her.

In your mind, it is always preferable to have a witness available to provide evidence before you so that you may explore any matters of concern that you may have, or to explore any further issues with her. In many ways, the Council is hamstrung to an extent by the patient not being here to give her evidence: it cannot ask any questions of rebuttal. The Council does not have any detail as to what either registrant is likely to say about what happened during their examination and, therefore, it is reliant solely upon the witness statement which she has provided and which appears before you in the bundle. That is a very detailed statement that deals with a number of matters over a period of time. The truth of it is affirmed by the affirmation at the end, and it is dated 15 April 2006. Madam, I make the submission that this patient is unfit to attend before you and, as a result, the Council rely upon her written evidence.

I said that my application is twofold. The second part is I would ask that, pursuant to Rule 38 of the Fitness to Practise Rules 2005, her evidence appear before you. Rule 38(1) states at page 99 of the *Opticians' Handbook* that:

“Subject to paragraphs (2) and (3), the Fitness to Practise Committee may admit any evidence they consider fair and relevant to the case before them, whether or not such evidence would be admissible in a court of law”.

In order for you and your colleagues to undertake a full inquiry into this case, you would be assisted by the witness evidence of this patient. What weight you apply to that evidence is entirely a matter for you in due course, but it will assist you, I suggest, in your deliberations. The evidence is clearly relevant, because I have said that this is the patient who is central to the case and to your inquiry over the next two or three days. I suggest that it is fair for this evidence to be available to you and considered.

Madam, it is a very brief submission, an application is before you. I suggest that the evidence is fair and it is relevant for you to consider as part of your wider remit of inquiry. Any concerns you may have as to the examination of this witness are able to be met by the fact that my learned friend is well able to make submissions to you as to the weight which you may apply to this evidence in due course, given that she is not in attendance before you. Thank you.

Ms Hallendorff: Mr Stern, please feel free to sit.

Mr Stern: I prefer to stand if I may, simply because it is the way I am used to doing things. May I say, first of all, that we have looked at the general practitioner's reports and, originally, the one dated 30 April was perhaps not as clear as it may have been, because you will have to decide whether the patient is fit on a particular day, that is to say, today. You will see from that report of 30 April that the patient had seen her practitioner, I believe, on about four occasions over the year before, the last occasion being 9 March, which was some time

ago. We now have an update which assists everyone in coming to a conclusion about the fitness or otherwise of the patient, and it is clear that Dr Daniels asserts that the patient is unfit to attend primarily on the basis of her mental condition. That is that and I do not seek to go behind that.

The second issue is whether or not you are satisfied that it would be fair to admit the statement and let me make it absolutely clear, if it is not already clear, that we do not accept all of the statement: there are a number of things about the statement that we would wish to ask the patient a number of questions. Let me just give you one other point about this, which is that the statement of the patient begins: "I have reviewed the representations made by Julian Davies, Sasha Macken and Wilfred Phillips in this matter together with my original allegation" in January 2006. Therefore, her statement is made having already seen the representations of the practitioners. That is just one of the points that one would wish to draw to your attention and there are a number of others.

Having considered the matter carefully, the issue is this. Would it under Section 78 of the Police and Criminal Evidence Act, or Article 6, be such that these practitioners individually could not have a fair hearing? On balance, with a degree of caution, we do accept that, taking into account all the representations that we shall make in due course about this statement, the practitioners can have a fair hearing.

Mr Swinstead: Mr Stern, are you agreeing to the admissibility of this statement or not?

Mr Stern: I do not object to it; it is ultimately a matter for the panel.

Mr Swinstead: Thank you.

Mr Stern: It is not for me to determine the issue but I do not object to it, if that makes sense.

Ms Hallendorff: Mr Alder, do you have anything to say in response?

Mr Alder: No, thank you, Madam, other than to agree with my learned friend that a fair hearing is easily achievable in the circumstances given the experience of this Committee.

Ms Hallendorff: We shall ask Mr Swinstead for his formal advice on this.

Mr Swinstead: Madam, I should formally advise you that Mr Alder, on behalf of the Council, has applied to place the statement of Patient A before you, because she is unfit to attend, and he has put before you the two medical reports which you have seen. He has referred you to the Criminal Justice Act 2003 and if I may briefly indicate the provisions of that Act that are relevant. Section 114(1) of that Act states:

“In criminal proceedings a statement not made in oral evidence in the proceedings is admissible as evidence of any matter stated if, but only if, (a) any provision of this Chapter”, i.e. that part of the Statute, “or any other statutory provision makes it admissible”,

and Section 116 which is part of the same chapter says at 116(1):

“In criminal proceedings, a statement not made in oral evidence in the proceedings is admissible as evidence of any matter stated if, (a) oral evidence given in the proceedings by the person who made the statement would be admissible as evidence of that matter; (b) the person who made the statement (the relevant person) is identified to the court’s satisfaction and (c) any of the five conditions mentioned in subsection (2) is satisfied”.

Subsection (2)(b) states:

“that the relevant person is unfit to be a witness because of his bodily or mental condition”.

That is the case here. You have heard Mr Stern say on behalf of the registrants that he does not formally object but he cannot agree and leaves the matter for you. I remind you that Rule 38(1) gives you the power to admit any evidence if you consider it fair and reasonable to the case before you that such evidence should be admitted, whether or not such evidence would be admissible in a court of law. I would advise you that it would appear that under Section 116 of the Criminal Justice Act 2003 it would be admissible, but you can apply your own rules as well should you feel it necessary to do so. Madam, I do not think there is anything else that I can advise you on. Would either party wish me to say anything else? I should perhaps say that Mr Stern has properly put the two matters before you. The questions are: is the witness unfit today and, secondly, should her statement be admitted before you because she is unfit? Those are the two questions and you have heard both parties on them.

Ms Hallendorff: Shall we take a brief adjournment so that we may discuss this and we shall reconvene in five minutes or so.

[Hearing adjourned at 11.28 am]

[Hearing resumed at 11.39 am]

Ms Hallendorff: Thank you very much. Mr Alder, on behalf of the Council, has applied for a statement of Patient A to be placed before the Committee in its written form because she is unable to attend the hearing to give oral evidence. The Committee has heard Mr Stern’s submissions in reply on behalf of the registrants and has received the advice of the legal advisor. The Committee has seen two letters from Patient A’s general practitioner dated 30 April 2007 and 18 May 2007. On the basis of the content of these two letters, the Committee is satisfied that Patient A is unfit to attend to give oral evidence

because of her health. Having considered the submissions of both parties, the Committee has decided that the evidence of Patient A is relevant to the case before it, and that it would be fair to admit the evidence in written form. So we can continue.

Mr Alder: Thank you, Madam. You will find a copy of the statement of Patient A on page 2 behind the index, it is the first document in both bundles for Ms Macken and Mr Phillips. For absolute clarity, Madam, you will see at paragraph 36 of both of the statements, the final sentence has been removed and is not evidence which you are to consider. I propose not to read the statement through, which was one of my reasons for referring to it at length during my opening. That, of course, was not evidence but it is information and evidence which is available to you now. The purpose of going into greater detail about her evidence in my opening was to allow that information to form part of the public transcript of this hearing, to ensure that all those listening and reading the transcript of this hearing will be aware of the symptoms which were presented by her. Therefore, I propose not to read the statement into evidence unless, of course, you feel that an appropriate step to take?

Mr Swinstead: Madam, it occurs to me that it should be. Mr Stern, are you content for it not to be read? It only occurs to me that it possibly should be read as part of the body of the evidence in the case, although, of course, the Committee can read it for themselves.

Mr Stern: It is an exhibit and, therefore, it is part of the evidence as such. However, perhaps it ought to be summarised. It does not matter to me personally one way or the other, because we have read it a considerable number of times but as it is a public hearing perhaps it ought to be summarised. However, that is perhaps a matter for Mr Alder and not for me. I just want to add that I am sorry we have two versions and I appreciate that it is perhaps not the most helpful way. If you look at Mr Phillips's bundle, perhaps I can familiarise you to help you see where there are things that are important, while we are doing this if you would not mind.

If you look at page 10 of Mr Phillips's bundle, you will see the letter of 17 January 2006 that was written by the patient. If you go back to page 2 of Mr Phillips's bundle, you will find the statement of April 2006, so that you have it chronologically in your mind. Pages 11, 12 and 13 are the meat of the case, as they are the patient records relating to 12 September 2005 with Mr Davies, 21 September at page 12 with Ms Macken, and at page 11 we have 10 October with Mr Phillips. After that, you have the hospital records. I do not know how much my learned friend will want to address you on but I would have thought very little. The critical page you will be referred to I believe is page 23. Up to there, both bundles are the same. Thereafter, you will see at page 52 the response of Mr Phillips to the Council and, if you look at page 51 in the other bundle, you will find Ms Macken's response to the Council, following which is Mr Harper's report at pages 53-58, and in Mr Phillips's bundle it is pages 54-58. It is only in the latter parts of the bundle that you

need to float between the two. I thought that that might help while we are on administrative matters.

Ms Hallendorff: Thank you.

Mr Alder: Madam, the issue at this point is whether to read the statement of the patient into the record. I am instructed that, if it would assist you to read the statement in its entirety, it would ensure that it is fully set out in the transcript.

Mr Swinstead: Mr Alder, from my part I would say that I would prefer the evidence to go in, although everyone can read it. I believe that it properly should go into the transcript.

Ms Hallendorff: Yes, please.

Mr Alder: Indeed, thank you. Madam, I begin by reading from Ms Macken's bundle at page 2. The statements are identical in both cases and the statement is dated 15 April 2006 and at the bottom of each page it states: "This statement, consisting of 8 pages signed by me, is true to the best of my knowledge and belief". This is the statement of Patient A set out and the patient identification schedule gives her address. [*Reads statement aloud*]

"1. I have reviewed the representations made by Julian Davies, Sasha Macken and Wilfred Phillips in this matter, together with my original allegation notified to the General Optical Council in January 2006."

Madam, that is the document that is set out in just the bundle of Mr Phillips, but that is equally relevant to both that case and this.

"2. I make this statement in support of my original allegation and to comment on the issues raised in the representations.

Relevant Background

3. I am 68 years old and I am a retired Radiographer formerly of the Heath Hospital in Cardiff. I retired from full time work at the age of 60. However, I was asked to return on a part time basis for a further four years.

4. My visit to Julian Davies Opticians on 12 September 2005 was my first visit. I had previously used Chalmers Opticians Ltd for approximately 10 years.

5. I decided to change to Julian Davies Opticians because it was closer to my home and the parking surrounding Chalmers was very congested.

6. I have been wearing spectacles for approximately 20 years and varifocals for roughly five years prior to going to Julian Davies.

7. My last eye test prior to my visit on 12 September was approximately 18 months before.

The examination, 12 September 2005

8. I attended an appointment with Mr Julian Davies at St Mellons branch near my home. I did not realise I was seeing Mr Davies himself as he did not make himself known to me.
9. I attended because I was concerned about my driving and the fact that my eyesight appeared to have reduced. I was still wearing varifocals and I wanted to ask whether it would be better to wear varifocals of separate glasses.
10. I discussed my concerns with Mr Davies. I told him that I had suffered from a retinal tear some years ago before and that I have Fuchs' Dystrophy. It is not necessary for me to take medication, as it does not affect my eyesight.
11. I remember looking at the eye chart and noticing that my right eye was bad, as I could just make out the first letter. I do not remember what other tests he did but I know that he did not take the pressure of my eyes.
12. I cannot remember what else was said during the eye examination but I do remember that he did not ask me any questions or about my family history.
13. At some point in the examination he walked out of the room, holding my old glasses in his hand, without saying anything to me. I do not remember what he was doing before this.
14. I waited for about quarter of an hour and just before I was about to go out to reception to ask what was happening, he came back into the room saying, "we'll start all over again". He did not give me any explanation as to why he had left the room or why we had to "start over again".
15. Mr Davies then looked into my eye and I re-read the eye chart. He asked if I could cope with varifocals and I explained that I had managed with them for 5 years with no problems. He suggested that I continue with the varifocals and that they would ring me when the new prescription was ready. He did not say anything else to me or advise me when to return to the practice.
16. He did not advise me that he had found early lens changes or cataracts, as he discussed in his representations, or comment on the general health of my eyes.

17. I picked up the new pair of glasses from the practice, I think about three days later. I had been wearing the glasses all day for about two days and I found the distance to be excellent. However, one evening I started to get a shooting pain above my right eye after doing close work. I tend to do a lot of craft work such as sewing, knitting and reading. I was able to place my finger precisely where the pain was coming from. I found this strange as I have never suffered from headaches.
18. I persisted with the glasses and my vision started to go blurry. This was about 11.00 pm at night. I decided to go to bed and when I woke up in the morning, the pain and blurred vision had cleared.
19. The same thing happened the following evening. However, because I was concerned about the unusual pain, I went to visit the practice again.

The examination, 21 September 2005

20. I went to the reception desk and asked if I could see someone as I was having problems.
21. A lady came out to see me called Ms Sasha Macken who took me to one side and she gave me a precursory examination. This involved looking into my eye with some sort of scope for a couple of minutes.
22. I told Ms Macken about the piercing pain and I pointed where it had been above my right eye. I also told her that it had happened several times. She told me that I was wearing varifocals and that it takes time to adapt to them. I tried to tell her that I had been wearing varifocals for 5 years without problems but she would not listen. She said, "They are new varifocals and you must persevere". She also said that the prescription was "satisfactory". She explained to me that some people take longer to get used to varifocals.
23. I found her manner to be very dismissive and she did not advise me to return if I was still experiencing problems.
24. I persevered with the new varifocals and I cannot say whether there was one night where there was no pain above my right eye. However, it was always fine when I woke up in the morning.

The examination, 10 October 2005

25. As my problems had not gone away, I went back to the practice where I saw Mr Wilfred Phillips who I believe is a locum optician.
26. Once again, the pain and blurred vision had gone by the time I saw Mr Phillips. I repeated my symptoms to him and pointed to the spot where I suffered from pain in the evening. I do not remember Mr Phillips

asking me any questions throughout the examination and he categorically did not give me any anaesthetic, either by injection or drops. I would remember something like that. None of the opticians I saw at the practice measured the pressure of my eyes at any point.

27. I cannot remember what tests Mr Phillips performed but I do remember that, after looking at my eyes, he walked out of the room with my glasses muttering to himself, "what the bloody hell's going on here". He came back into the room after a few minutes and said, "got it". He did not explain what he meant by this. However, he did explain to me that the lower part of my varifocal lenses were too strong and that he would prescribe a lower strength. He did not give me any other advice at the end of the examination or tell me when to return if the pain continued.
28. I am not absolutely sure but I think I rang the practice about a week later and I would have then gone to pick up the second pair of varifocals.
29. I started wearing the new pair of glasses but they had the same effect as before. Over a period of about three weeks, I had been wearing my old glasses and I did not experience the problems of pain and blurred vision as I did when wearing the new glasses.
30. I struggled on with the new pair of glasses. I was experiencing pain, on and off, in the evenings. I could not put a figure on it but it was definitely a lot more than the three episodes he states in his representations.
31. I telephoned the practice to try to get to the bottom of my problem. I spoke to a technician and I explained that the pain had not gone away and I was still experiencing blurred vision and headaches. The technician conveyed that Mr Phillips had said that I might need to wear separate glasses, so I returned to the practice.
32. I picked up the separate glasses, one pair for distance and one pair for close work, on a Friday. I vividly remember on the Saturday I was watching the All Blacks on television and I started to feel an extreme stabbing pain above my right eye, my vision became blurred once again and my entire eye had gone red. I did not get any sleep that night and I decided to go to casualty at approximately 5.00 am on the Sunday morning.
33. I saw the house doctor on call and he said that it was probably glaucoma. I explained that I had experienced continuous pain for about a week and sporadic pain for about three and a half weeks.
34. The house doctor took me to a ward at about 07.30 am where they tested my eye pressure. I was told that it was 64 and that anything over 60 could result in the permanent loss of vision.

35. I then saw Dr Wong who would not let me leave the hospital until the pressure had dropped. He conducted various tests and he kept putting drops in my eye to reduce the pressure. I left at some point in the afternoon because my eye pressure had reduced to around 40. I was referred back on Monday morning for further tests. It appeared that they tried everything to reduce the pressure but it would go down, only to go straight back up again.
36. I was referred to a Dr Kumar who explained to me I had acute glaucoma. I explained the story to him of how I had had various problems with my new glasses.
37. Dr Kumar explained that he would have to perform trabeculectomy surgery in my right eye in order to let the pressure drop. I was referred to day surgery and given a local anaesthetic. On the day I went into have surgery, my eye pressure was 50. After the surgery, I had to go back every two days. It then changed to every two weeks and subsequently every four weeks.
38. Even though Dr Kumar told me that the surgery had been a complete success, my eyesight is not perfect and I have approximately 85% of my full vision left. I was told that there is a 10% chance that the glaucoma may reoccur. I still wear glasses and I am due to see Dr Kumar in six months' time.
39. I wrote to the opticians to complain about my experience and I was offered credit, which I refused.
40. I then reported the situation to the General Optical Council as I was concerned about why important warning signs were missed by these opticians. If I had not attended the hospital, I may have lost my sight completely, and I would not want this to happen to anyone else."

Ms Hallendorff: Thank you.

Mr Alder: Madam, I am conscious that at this point I would call Dr Harper and his evidence, as you would expect from an expert, may take some time, and I am conscious that you indicated before deliberating as to whether to admit this statement whether you would appreciate a five-minute coffee break or a brief adjournment?

Ms Hallendorff: We have had a break; that is fine, please continue.

Mr Alder: Madam, if I may please then call Dr Robert Harper?

DR ROBERT HARPER sworn
Examined by MR ALDER

Q. Dr Harper, you should have in front of you two bundles, and I apologise that there are two bundles. The first bundle contains your expert report in respect of the care provided by Ms Macken. I would ask you to turn to page 6 please.

Ms Hallendorff: It is in fact page 53, Mr Alder.

Mr Alder: Dr Harper, I wonder if I could quickly go through your curriculum vitae, I see you have a copy in front of you. You graduated from City University with a First Class Honours degree in Optometry in 1986.

A. Correct.

Q. After a pre-registration year at Moorfields Eye Hospital, you registered as an Optom in 1987 and were awarded a number of prizes. You hold both academic and professional post-registration qualifications and a Master of Philosophy from the University of London in 1989, a doctorate from Oxford in 1992 and a Diploma in Glaucoma from the College of Optometrists in 2005.

A. That is correct.

Q. You state in your CV that you have a wide range of optometric experience in the clinical academic teaching and audit domains, and you contribute to wider professional matters within the optometric profession. I wonder whether you could expand a little on your optometric experience before the Committee.

A. I have been registered as an optometrist for 20 years and in my present post I spend about 50 percent of my time with direct hands-on clinical work with patients. The remainder of my time is focused on management-related matters but also teaching, audit and research. At the eye hospital, I am audit lead, I have external professional contributions that I make in terms of examining at all levels in the profession both at undergraduate level, post-graduate in terms of optometrists in training, and also postgraduate in terms of higher qualifications awarded by the College of Optometrists. I contribute towards continuing education and training both in terms of lectures, seminars and so on, and production of articles for the profession. My career had probably more of an academic slant in early years.

During that period of time, I was also a locum optometrist spending a proportion of time practising in high street optometric practices both in the independent sector and in the commercial sector, although more recently my work has been involved with the hospital eye service. I also contribute to matters to do with professional development, local service implementation. I have been the hospital's representative on the Local Optical Committee and during that period of time we introduced the Manchester Glaucoma Referral Refinement Scheme. I believe that reasonably reflects the scope of my work, which has probably tended to sway back more towards clinical matters in recent years rather than academic matters, for which unfortunately I find myself having less time than I would like.

Q. Can you explain your role with the hospital eye service?

A. My present role with the hospital eye service is that I am an optometrist consultant at the Manchester Royal Eye Hospital, responsible for the provision of a number of services and staffing for providing those services, primarily to do with low vision, refraction work but also our optometric-led glaucoma assessment clinics. So my role encompasses clinical work in which I personally participate but I am also responsible for those services and the other staff providing those services on a day-to-day basis.

Q. And your work with the Local Optometric Committee?

A. That was to act as hospital representative for a five or six-year period. I stood down a couple of years ago. My role there would have been that, from the hospital's perspective, we hosted the meeting and it was chaired by a local community optometrist but I was providing input from the hospital's perspective. This included the implementation of this referral refinement scheme for glaucoma.

Q. The Committee have available to them a copy of your report and, unless the Committee would prefer otherwise, I do not propose to ask Dr Harper to read it through, but to take him through it for matters of clarification. I am conscious of the direction given by the Committee regarding the witness statement from the patient, so if Dr Harper is asked to read it through, I am entirely in the Committee's hands.

Mr Swinstead: Mr Alder, I should have made it clear that it was only because the witness was not here and it was her evidence. Therefore, I advised the Committee accordingly but, if you have the witness here, you may take him to those parts of the report you wish to.

Mr Alder: Thank you, Sir. Dr Harper, you referred throughout these cases to the diagnosis of acute narrow angle glaucoma with which this patient was diagnosed in November. Slightly putting the cart before the horse initially, can you just explain the nature of narrow angle glaucoma and the symptoms?

A. This is a less common form of glaucoma in the sense that optometrists mainly come across a form of glaucoma called open angle glaucoma, which is usually asymptomatic until very late on. Angle closure glaucoma produces symptoms that can be acute or sub-acute, and these will include pain within the eye, blurring of vision, noticing possibly halos around lights. The patient may have noticed the sign of a red eye and there are a number of signs that the optometrist would note: potentially red eye and significantly markedly elevated intra-ocular pressure. I have to say that this would be during a period known as an acute attack of angle closure glaucoma, but in as many as a third of the cases of angle closure the patient, rather than present with a full blown angle closure glaucoma attack, will present with a range of those symptoms in what are known as intermittent or sub-acute angle closure glaucoma attacks, which spontaneously resolve and do not necessarily result in the patient attending a hospital casualty department.

Q. You refer at page 54 of the bundle, in the second paragraph, to the symptoms which Ms Macken has recorded for the patient, these being reduced distance

vision, headaches and pain. Can you explain what steps should have been taken, in your opinion, at that stage –

A. Sorry, there was a cough; could you just repeat the second part of the question?

Q. Yes, could you explain what a reasonably competent optometrist would do with a patient presenting with those symptoms?

A. I believe that pain within an eye warrants a slit-lamp examination in particular. This patient, it is understood, has had an eye examination a few weeks or 10 days before, so there isn't necessarily a requirement to conduct a full eye examination but the patient seemed to be presenting with some new symptoms that she was not presenting with when she first attended on 12 September 2005. So, in my opinion, a presentation with the symptom of pain in one eye would warrant the optometrist to undertake additional tests that were not undertaken on this occasion. In particular, this would involve examination of the eye using a slit-lamp.

Q. Can you just explain the background? You refer to pain and you do so on a number of occasions in your report. Why is pain a significant symptom for this patient?

A. Pain is a symptom that can be attributed to a range of ophthalmic problems. It can be completely innocuous in the sense that it could be pain due to dry eye: sometimes patients present with a dry eye, which is not a harmful ophthalmic problem, it can be a source of irritation but patients can report a stabbing pain. Pain, on the other hand, can be quite a serious matter and it can, as was the case in this particular instance, be attributed to a more serious ophthalmic problem. Therefore, a patient presenting with pain warrants investigation to try to find out whether it is pain that is of a less serious nature, or pain that might potentially be due to a sight-threatening eye condition.

Q. Why do you focus on the slit-lamp examination with that symptom?

A. It is a question of finding the explanation for the symptoms, and the slit-lamp is an extremely useful tool to examine the anterior segment of the eye, the conjunctiva, the cornea. It would have been possible to identify the problems of a dry eye, it would have been possible to have identified other differential diagnoses of ocular pain: was there any redness around the edge of the cornea, was there any activity in the anterior chamber that might have signified that the patient was suffering from an inflammation within the eye? Those two conditions I mentioned are nothing to do with acute angle closure glaucoma. Equally, it would be possible for an optometrist, when conducting a slit-lamp examination, to look at the anterior chamber and decide whether or not the patient might be at risk of an angle closure glaucoma attack. So it is a fundamental instrument for assessing pain as ocular symptomatology?

Q. The use of the slit-lamp itself, is that a specialist examination or a generic examination available to all optometrists?

A. In my opinion, it is not specialist; it is a fundamental piece of optometric equipment that is highly applicable in a range of scenarios.

- Q.** What standard are you applying? Are you applying your hospital standard?
- A.** I am applying the standard that one would reasonably expect of an average competent optometrist in practice in the community.
- Q.** How about with respect to the students whom you would be examining or teaching: would they have an understanding of the use of slit-lamp examination?
- A.** Yes, I believe so. Certainly, students who reach the more clinical stage of the course in the third year and, of course, students who have graduated with a degree in optometry and in their pre-registration year, it would be reasonable to expect them to have an understanding of the application of this instrument at entry level for the profession.
- Q.** One of the matters you touch on in your report is the requirement to measure intra-ocular pressure. With the symptoms presented by this patient, please could you explain to the Committee your opinion as to whether intra-ocular pressures should have been examined or not?
- A.** This is a sort of sequential decision that one makes when applying tests to patients. The patient was not seemingly experiencing an attack of angle closure glaucoma at this point in time. There was not the catalogue or full range of symptoms attributable to angle closure which do not seem to be written either on the record card or in the statement of Patient A at this particular point in time. So I am not suggesting that intra-ocular pressures should have been measured because they were present; I would say that the full range of symptoms was not present. However, the examination conducted on 12 September 2005 by Mr Davies did not include the measurement of intra-ocular pressure. This patient has re-presented with some new symptoms and I believe that the earlier omission of this test should have been rectified on this occasion because of the possibility that the pain could have linked with raised intra-ocular pressure in this patient.
- Q.** You say that this test should have been performed. The record is available for you at page 11 of this bundle. It says very clearly in the top left-hand corner that this is a re-check, not a full sight test. Does your opinion remain the same or differ if this was a re-check?
- A.** If it was a re-check and the patient was presenting with difficulty tolerating spectacles, and she was presenting with blur, pulling, some other symptoms, but pain I believe deserved something different in terms of investigation – pain in one eye. It is not usual, in my experience, for a patient to present as a non-tolerance case with spectacles with pain in one eye. Therefore, I believe that further investigations were indicated. If, on slit-lamp examination, some source of that pain may have been identified, it might be possible not to have carried out the intra-ocular pressure test. What I am suggesting is that, in the absence of securing an explanation for the pain, it would have been one of the tests to have conducted.
- Q.** I want to come back to further examinations. Your point there is that the optometrist should be seeking to secure an explanation for the symptoms. The registrant has concluded there is a spectacle tolerance issue happening

here. Can you explain whether that is an adequate explanation and, if not, why?

A. In my opinion, I do not believe it is an adequate explanation because it does not explain the symptoms that the patient indicates she communicated to the registrant. Moreover, it does not explain the symptoms as recorded on the record card, which is pain in the right eye.

Q. In what way?

A. In my opinion, pain in one eye is not something that can be explained due to spectacle tolerance problems. It is not necessarily impossible. Anyone who works in clinical practice has to concede that there are all sorts of ways in which patients will report subjective symptoms, and some patients are more reliable than others. However, in my opinion, particularly in an instance where the prescription is unchanged, we do not seem to have an adequate explanation. The optometrist when faced with such a scenario should keep an open mind and should conduct some tests to ensure that the patient's symptom of pain is not attributable to some other finding.

Q. With respect to undertaking ocular investigations to try to identify the cause of her symptoms, as you refer to in your report what other ocular investigations could or should have been undertaken?

A. Again, this would be sequential. I believe that a slit-lamp examination, as mentioned before, would be the primary instrument to reach for and on this occasion it may well have been possible to have made the link with the symptoms, because this patient will almost certainly have had a narrow anterior chamber angle.

Q. Can you just explain what you mean by that?

A. The anterior chamber angle is the angle between the iris – the coloured part of the eye – and the cornea – the clear window at the front of the eye. Fluid is made behind the iris in the eye by a structure known as the ciliary body. It flows from this part of the eye, known as the posterior chamber, through the pupil into the anterior chamber, and it usually filters out of the eye through an angle between the cornea and the iris. In some predisposed individuals, this angle is narrow and is potentially closable, and these are the sort of patients who are at risk of angle closure glaucoma. There is no suggestion on this occasion that this patient was presenting with the full complement of symptoms of angle closure. I am merely saying that, on conducting a slit-lamp examination, the presence of a narrow angle would have been identifiable to the optometrist, and that is the point I make.

Q. At this point on 12 September?

A. Yes – on the 21st I believe we are referring to.

Q. On the 21st. To your understanding, would that be accepted to be a standard view within the profession, or is that a matter of academic speculation that the narrowing would have been noted on 21 September?

A. I do not think you need any formal assessment of the anterior chamber angle in this sort of scenario. If someone has a shallow anterior chamber angle, it is fairly self-evident that that is so when using the slit-lamp. It is not a procedure

that has super high standards. It is not a higher diploma assessment. It is a fairly standard level assessment of the eye.

Q. You conclude in your report that the ocular structures within the eye should have been examined at this point by Sasha Macken. What ocular structures would you expect to be examined during this test and how would they be examined?

A. In particular, it should be a focused re-check based on the presenting symptoms. We have heard about the symptoms that the patient says she conveyed to the optometrist, and we can see on the record card the symptoms that are recorded as identified by the optometrist in terms of what Patient A reported. Again, I believe that this sort of symptomatology would have or should have resulted in an investigation of what I would call the anterior segment of the eye, the cornea in front of the eye, the eyelids, the lashes and again looking at the anterior chamber angle, looking at the anterior chamber itself to see if there was a possible explanation for the symptoms of pain.

Q. Is there any record at all from the record completed by Ms Macken that those have been completed?

A. No.

Q. You refer to an assessment of her presenting symptoms and the charge put is that there was inadequate assessment. What would you expect to have formed an adequate assessment of the symptoms with which she presented?

A. I go back to the use of the slit-lamp, because this is the primary tool to investigate a patient complaining of this sort of symptom. Again, it is possible that there is ocular pain due to other factors and pain may present due a patient manifesting an eye movement problem. It could be that the patient has some more posterior eye problem but, more commonly, patients present with problems that are more anterior eye related, and that is why I suggest that the slit-lamp would be the first line instrument in a patient presenting with this symptom. In the event that there was no problem identified with that particular test, it may have been appropriate to conduct other tests. I would not suggest that all of that battery of tests would be needed on one occasion.

Q. Do you often see patients - as a clinician - who attend with spectacle intolerance problems who present with symptoms of pain?

A. With symptoms of pain, no, not in my experience.

Q. What is your experience?

A. I have 20 years' clinical experience and during all of that time, I have spent at least some time having direct contact with patients – in the last 12 years it is about 50 percent of my timetable. Some of those sessions will be spent on sight testing patients attending Manchester Royal Eye Hospital and, due to the nature of spectacle prescriptions in a hospitalised service, we commonly have patients who struggle to adapt to new spectacles. However, in my experience, the symptom of pain is not something that is typical; I have not come across it as a symptom.

Q. At page 56 of the bundle in the final paragraph of your report, you state there:

“Whichever version of events is correct, there would appear to be agreement about the presence of a drop in distance vision and the presence of pain in the right eye”.

A. You have had the opportunity of reviewing the statement of the patient and –
Sorry, can you orientate me as to where you are?

Q. It is about half-way down your final paragraph?

A. Sorry, which page is that?

Q. Page 56 of the bundle. You say:

“Whichever version of events is correct, there would appear to be agreement about the presence of a drop in distance vision and the presence of pain in the right eye”.

You have had available to you a copy of the statement of the patient and also the response presented by Ms Macken. Even if you discount the patient’s evidence, so what you have to go on in the records and the response, does your opinion remain the same or differ as to what steps a reasonably competent optometrist should have taken?

A. It remains the same.

Q. I want to ask you briefly about your supplementary opinion at page 58 of the bundle. This will involve you flipping between the response of Ms Macken which starts at page 51, so the hospital records on page 22 of the bundle. At page 52 Ms Macken states: “Having reviewed Patient A’s medical records, I note that on a visit to the Heath Hospital in Cardiff on 6 November 2005 she reports an onset of symptoms of only one week”. In your opinion, you take issue with that. Referring to the hospital records on page 22, could you just explain the background to your opinion on the date of onset?

A. The patient appears to have presented with an awareness of their red eye. There is a comment right at the top of the entry on page 22 from the examination by the ophthalmologist dated 6 November 2005: “PC”, which I interpret as patient complained, “red right eye” and then it is “onset 1/7 ago”. I believe in my report in different stages on one occasion I have mentioned a day and on another occasion I have mentioned one week. Of course, the correct interpretation is that 1/7 refers to one day. However, the point I was making at this particular moment in my report was that the symptoms are noted to be pertaining “previous episodes in the past x3 within three weeks resolved spontaneously”. Further down it says “feels eyes have become like that since having new glasses 3/52 ago”, so it is merely making the observation that the symptoms in respect of the record card at the hospital are for three weeks.

Q. For an optometrist, how important is, first, accurate record-keeping and, secondly, interpreting others’ records?

- A.** It is very important of course but that is down to the clarity of the records. There are some acronyms and terms that are perhaps universally understood and others that are a little more obscure. We have had an illustration of the 1/7 where in my own report on one occasion I talk about one week and on another occasion I talk about one day, so clearly that particular matter is perhaps open to interpretation. We know there are seven days in a week but we all know that 1/52 is more commonly used as an abbreviation for weeks, 1/12 refers to months.
- Q.** You also make reference to the referral in both Ms Macken's and Mr Phillips' response to minor corneal changes being recorded by Mr Davies at the test on 12 September. That is on page 12 of the bundle. Both in their responses refer to minor corneal changes (Fuchs' Dystrophy). I wonder if you can explain what Fuchs' Dystrophy is and then confirm whether there are any references made to minor corneal changes on Mr Davies's record card?
- A.** Fuchs' Dystrophy is a condition that affects the posterior or back layer of the corneal endothelium, and it can range from fairly mild, which seems to be the case for Patient A, to something more serious requiring patients to undergo a corneal graft. However, the point I tried to make in my report was simply that this patient appears to have mentioned to Mr Davies at the examination on 12 September 2005 that she had this condition along with the retinal tear, and that these matters are noted under the previous ocular history section of the record card, but my interpretation of the record card is that there is no comment as to his examination of the cornea on this occasion, nor on the subsequent record cards for the examination conducted on 21 September 2005 and on 10 October 2005. In other words, the comment on the cornea is entirely related, in my interpretation of the records, to what the patient says she has and not what the examination is as per the findings of the optometrist.
- Q.** Thank you. I shall not ask you those questions in respect of Mr Phillips as, clearly, they apply to both. For completeness, what is your view of the records of Ms Macken during the test on 21 September 2005?
- A.** In the context of a retest for a patient, if it is accepted that this matter was a re-check matter, the record card is adequate. The reason I have offered in my own opinion is that the symptoms were not adequately explained on account of spectacle intolerance and, therefore, other test procedures were indicated and, therefore, because those other test procedures were not undertaken and there is no record of them, the record card is not adequate.
- Q.** Thank you. Dr Harper, I would like you to comment please on the opinion which is put forward by the Association of Optometrists by Dr Eperjesi. It is a difficult process at the moment because, as we currently stand, this opinion is not admissible as evidence before you but I am conscious that now is the opportunity for Dr Harper to be able, quite properly, to give any comment he has on that particular opinion. Therefore, I propose to ask Dr Harper to go through the conclusions of Dr Eperjesi and to comment upon them. I am conscious that the Committee have not seen Dr Eperjesi and they may, in due course, think it inappropriate but that is a matter for this hearing in due course. However, I am conscious that now is the opportunity for Dr Harper to be allowed to comment upon this particular evidence.

Mr Stern: If you are going to hear a witness's view of a particular report, I would have thought it makes abundant sense for you to have the report in front of you, otherwise how is it that you will understand the point that he is making? I would have thought that was fairly obvious. We have the report here, we can direct your attention to the relevant page and you can understand what it is that the witness is saying. Otherwise, it will not make sense, will it?

Mr Alder: Madam, I am entirely able to understand what is obvious and not in this case, my point being that the defence representatives have chosen to ignore the timetable for disclosure of all the documents in this case. Therefore, technically, according to your rules, you have to be, first, subject to an application that those matters be available as evidence before you. I am conscious that that would ordinarily happen at the point at which both of the registrants are putting their defence case. I am conscious of not wanting in any way to anticipate how the Association of Optometrists wish to present their case, but I am conscious, of course, that Dr Harper is in a somewhat difficult position of being entitled to respond to the expert opinion that the Association will seek to rely upon. Madam, it is a difficult position to be in, to be frank. This evidence is not yet admissible or admitted before you, it requires an application on behalf of my learned friend to do that and it may be that he chooses to make that application now; that is a matter for him. I am beyond anticipating what may be obvious in the minds of the Association of Optometrists and what is not.

Mr Stern: I am assuming that Mr Alder has no objection to the report going in, otherwise he would not seek to ask questions of his witness about the report that he anticipates may or may not be inadmissible. Do I understand that the Council have no objection to the report going in?

Mr Alder: Of course, that is ultimately a matter for the Committee, it cannot be taken as the Council's position that it accepts in any way the position which has been taken by my learned friend and the defence team in seeking to include such evidence late and some would say to perhaps ambush the Council in late submission of documentation. There is a very clear timetable for disclosure set out in November of last year. In fact, the expert reports were served on 9 May. The character references, which again presumably form part of the Association of Optometrists' presentation, were not served until yesterday morning. So there is a very clear issue about the timetable which was set by other colleagues of yours at a previous Committee, and you may consider whether they should be admitted at this stage because of such late notice.

Mr Stern: I can go into the reasons but I really do not want to waste the Committee's time. Thirteen days is hardly an ambush but, leaving that aside for a moment, Mr Alder has not answered the simple question as to whether or not the Council object. If they do object, then we have to argue it; if they don't object, then obviously we don't and we can deal with this matter, I would have thought, fairly swiftly.

Mr Swinstead: Mr Alder, it is a slight cart and horse situation isn't it, because if for any reason this report were not to come before the Committee, then there would be no point in your asking the question.

Mr Alder: Indeed, Sir, which is why I have predicated my comments.

Mr Swinstead: The real question is do you formally object to Mr Stern putting that report in, and are you asking the Committee under its Rules to decide whether it should be accepted because it was received within the 14-day period? That is the real issue because then Mr Stern probably would formally have to apply. It is a matter for the Committee but there may be logic in the Committee reading that report at this stage now so that they understand the points that you want to make, because in various cases the Committee have had the opportunity to see both reports before the hearing so they understand the issues between the experts. However, I believe we need to do this in stages. If you are formally asking the Committee to decide to receive it, the Committee will have to do that and Mr Stern will have to make his application now.

Mr Alder: Sir, again the Council is in a difficult position to the extent that it always seeks to ensure a fair hearing. On the one hand is the Council's position as to these two cases. However, on the other hand, there are very clear reasons for a timetable for the disclosure of evidence being set out. That was the timetable set out in November of last year. The service of evidence has happened very, very late in the process and for that reason, if only to uphold the integrity of the procedure which is set out in the rules and with which all parties are said to agree and comply, the Council would seek an application to be made by the Association of Optometrists for the correct delivery and disclosure of this evidence and consideration by the Committee. I agree with you that I can see real advantages in there being a pre-reading if the Committee conclude that it should consider this evidence.

Mr Swinstead: Madam, you have heard what Mr Alder has said. What is sought is, therefore, for Mr Stern to make an application under Rule 38(3) because, as I understand it, the particular report was not served within the timetable as set out under Rule 32(2); is that right?

Mr Stern: I may have to call Mrs Mitchell to deal with that and maybe I shall need to take instructions as to exactly why that was. While Mr Alder is giving you a discourse, as it were, of both sides of the argument that is not really the help that you require. The help that you require, if I may say so with respect, is do the Council object to these reports going before the Committee, so that you know whether or not you have to make a decision? If you do not have to make a decision, then we are wasting a lot of time.

Mr Swinstead: Mr Stern, I believe what Mr Alder is saying – and he will correct me if I am wrong – is that he does not formally object but he wants the Rules complied with. Is that right?

Mr Alder: That is absolutely right, Sir, because there is a very important issue about the integrity of the procedure.

Mr Swinstead: I understand the point. Mr Stern, I think what Mr Alder is saying is that there are rules that should be complied with. He does not object to it but under Rule 38(3) we are very sorry we didn't do it on time, please can we admit it?

Mr Stern: If you will just give me a moment, I shall try to explain to you why it was that this was given late. [*Takes instructions*] Madam, may I say I have taken very brief instructions. As I understand it, there was a change in legal representation for reasons I am afraid I am not able to go into, which is why the documents were served late. They were served some time before I came into the case and, when there was a change of lawyer, it was dealt with expeditiously. It is really not very attractive, if I may say so, for a professional body to seek to stick to rules without knowing what the reasons are. It is a little unattractive when these have been served on the other side. Dr Harper is an extremely experienced expert and I am sure he has had plenty of time to look at them. If he has not had time, I have no doubt they would have asked for more time. The Council have not suddenly been asked to obtain an expert, they have had one already, so he has had to look at Dr Eperjesi's reports. They are there and the points are rather straightforward as to what Dr Eperjesi says, there is no prejudice at all to the Council. Quite frankly, this does leave a slightly bad taste in the mouth of those who like to have fair hearings.

Ms Hallendorff: If Mr Stern is making the application for the submission of the witness statements and Mr Alder is not putting in a formal objection, we shall accept that under the circumstances.

Mr Swinstead: Madam, may I just interject here because I am aware that there may be other documents in this bundle which should not be seen by the Committee at this stage.

Mr Stern: At this stage, Madam, you are being asked to look at divider 1 and divider 2 - that is all. Mr Alder is cross-examining, so I do not know to which parts he will refer you but the reports are in divider 1 and divider 2.

Mr Swinstead: Madam, therefore, may I formally advise the Committee not to look at any other part of the bundle but whatever is in divider 1 and divider 2, which are the reports of Mr Eperjesi. [*Further documents are distributed*]

Ms Hallendorff: In normal circumstances, the timely production of documentation is important but we accept that in this case - without knowing the details - there were extenuating circumstances.

Mr Swinstead: This is a matter for both parties: would it be helpful, Mr Alder, before you ask those questions if the Committee had the opportunity of reading these two reports, so that they have – to put it colloquially – in the palm of their hands the points between the experts. This may then assist them to

understand both your questions to Dr Harper and, more particularly and importantly, his responses. I do not know whether the parties think that is a good idea or not?

Mr Stern: It is immensely sensible, if I may say so with respect. You may want to read Dr Harper's report, as you have only just received it, and, although you have been through part of it, you may want to read it in full and Dr Eperjesi's report as well. I can tell you, if it helps, what the central issue is and I hope it will make matters clearer, if my learned friend has no objection to my saying what the issue is.

Mr Alder: In essence, this witness is still in the middle of –

Mr Stern: He has been asked those questions.

Mr Swinstead: Mr Stern, may we just leave it there. If it is thought by both parties, Madam, that it is a good idea that you read these reports, and indeed Dr Harper's reports, it may then assist everybody when Mr Alder continues his examination-in-chief.

Ms Hallendorff: [*consults*] We shall follow that advice and I believe lunch is served now. We shall take time to read it and then reconvene at half-past one. I am sorry, Dr Harper, to break in the middle of your evidence.

Mr Swinstead: May we just give Dr Harper the warning that he is giving his evidence and, therefore, should not speak to anyone.

Dr Harper: I understand.

[*Hearing adjourned at 12.44 pm*]

[*Hearing resumed at 13.31pm*]

Ms Hallendorff: Thank you. Before we continue, just a small matter of housekeeping. We have to be out of here by 5 pm, so when we come to a suitable break, if it is a little early it will make sense to break then rather than stop somebody in the middle. We have now had an opportunity to read the two witness statements and I think we can proceed with Mr Alder continuing to examine Dr Harper.

Mr Alder: Thank you. Dr Harper, I think you have there in front of you a bundle which includes the two expert reports. Can I refer you, please, to the expert report in respect of Macken, pages 1-15 of the bundle? It is a very broad question. I wondered if you have any comments to make upon the expert opinion presented by Dr Eperjesi. You can go through paragraph by paragraph.

A. I'll speak, perhaps, in a generic sense if I may, and then be led by questions if that is appropriate. The substantive issue as I would see it seems to relate to the significance of the symptoms of this patient. We have on the one hand what the patient says she communicated to the optometrist and then we have

the information that is recorded on the record card. I think there is agreement about the presence of a drop in visual acuity, and there is also agreement about the presence of blur. The term 'visual acuity', if I might just correct myself, is not the sort of language a patient would use. I think the optometrist would typically convert that, and we have that on the record card for the examination for 21 September 2005, 'Distant vision decrease', and then there is a comment, 'pain', and so on.

Dr Eperjesi, if I am correct, in summarising his expert witness evidence, says that he feels that this symptom could reasonably be explained out of the patient's non-tolerance to varifocals, as was the case in this patient's spectacle prescription. I believe the substantive difference between us is that my view is that that is not the case, and that pain, and particularly pain in one eye, is not normally the sort of symptom one would associate with spectacle non-tolerance, and the combination of pain with blur warranted further testing and investigations. I believe, in summary, that is probably the leading issue between the two reports.

- Q.** You say that pain would not normally associate itself to a non-tolerance. What do you mean? What is your background for that conclusion?
- A.** Personal clinical experience. I am not aware of any scientific investigations into the matter of spectacle non-tolerance. There may have been some, I am not aware of them. In my experience of dealing with non-tolerance issues and experience of dealing with training optometrists who I supervise who are dealing with non-tolerance issues, the sort of symptoms patients may come in complaining about are difficulty with glasses, sort of pulling sensations sometimes. Sometimes they might complain of blurred vision at distance or near. They might talk about strain, but it would be unusual to have a patient complain about pain due to non-tolerance in my opinion.
- Q.** Could I take you to what I understand is page '7' of that bundle. In the third paragraph Dr Eperjesi refers to primary angle-closure glaucoma being a rare condition. Does the rarity, or otherwise, have any affect in your mind or in your opinion, as to the steps to take with the symptoms presented?
- A.** First of all, as stated, I would agree with him. It is a rare condition. We know the incidence is something of the order of 7 per 100,000 of the population, so it is rare. We are in agreement on that. It is just that the symptoms that this condition can present with when in its full-blown extensive capacity as described in my own witness statement, are pretty characteristic of that eye problem. However, the selected symptoms that the patient said that she reported to the optometrist on this occasion are not those that are exclusively possible due to acute angle-closure glaucoma, but they would fall within the range of symptoms that might be experienced by a patient suffering intermittent attacks prior to an acute attack of angle-closure glaucoma. I believe it would be incumbent on an optometrist, despite the rarity of the condition, to consider that pain might actually be due to something else other than spectacles.

I think it is easy with the benefit of hindsight to make a link between the symptoms and the presentation at the time the patient was examined. My

opinion is that there was something more than a spectacle non-tolerance present, but not necessarily something that was waving a flag saying 'this is a case of intermittent angle-closure glaucoma'. I wouldn't go that far. I don't think that is evidence that is available in the information presented. I would argue that there is clearly something going on here above and beyond spectacle non-tolerance in my opinion.

Q. Given the agreement with you as to the rarity of the condition itself, would you expect within the profession a reasonably competent optometrist to understand, though, the link between these symptoms and glaucoma?

A. Yes.

Q. Again, on what level? Is that a basic level, or is that a gold standard level?

A. No, it is basic entry level. You would expect an optometrist to have a knowledge of the symptoms of acute angle-closure glaucoma. Some acute attacks, a differential diagnosis of a red eye is a key aspect of an optometrist's training. I believe we are not talking about a specialist level of knowledge there. Although this is a rare condition, retinal detachment is also a rare condition, but the symptoms are ones that all optometrists would be mindful of, and knowledgeable of, at whatever level within the profession.

Q. Thank you. If I could ask you to turn to page 10 of Dr Eperjesi's report. In his conclusions, Dr Eperjesi relates to this being a re-check examination as opposed to, presumably, a full examination. The fact that it is termed there a "re-check examination", does that in any way alter your view as to what steps should have been taken by a reasonable optometrist?

A. I think if it is a re-check examination and the patient is complaining of matters that relate to the use of her spectacles, then it would be reasonable to have conducted an examination accordingly, selectively testing, for example, repeat testing vision acuity, refraction sight testing, checking the focus of the eyes, possibly the muscle balance of the eyes and so on. As I was expressing before, where the patient symptomatology goes beyond that, I believe it was incumbent on the optometrist to do more than that.

Q. When you say it was "incumbent", what do you mean by that?

A. It would be in their patient's welfare for them to have conducted further tests to try and identify the cause of the symptoms and to exclude the possibility that there was something else other than spectacle non-tolerance. We need to remember here that this patient's prescription hadn't changed, so essentially at the re-check it hadn't changed from the first test. Therefore the optometrist had found similar findings to the colleague. The patient had worn varifocals previously, so I believe it would have been reasonable to have been looking for some other explanation.

Q. Thank you very much. Now I would like to turn you to, if I may, the report of Mr Phillips. The report is on page 54 of the second bundle. The ultimate result of this examination by Mr Phillips is that he changes the reading prescription for the patient. Could you just explain the background to that and the nature of the change?

- A.** My understanding is from the information available on the record card that Mr Phillips has prescribed a stronger reading prescription, not as is stated in the patient's witness statement actually, but a stronger reading prescription. It is quite a significant change in fact to the tune of one dioptre, which is quite a large step/change, from the previous examination by his colleague, Ms Macken. I confess to being unsure whether initially that new prescription was made up in a varifocal format and then to be subsequently changed to separate pairs of spectacles on a later occasion following a telephone conversation, or whether the separate pairs of spectacles were actually dispensed following that re-check on 10 October. That could be confirmed elsewhere.
- Q.** What does that one dioptre change mean?
- A.** It is a significant increase in the reading prescription for that patient. I would expect a patient coming in who needed such a change to be complaining of difficulty seeing to read small print. Possibly the symptom of needing to push their paperwork much further away, but actually struggling to obtain sufficient visual acuity. So I would certainly be looking to see visual acuity with the existing correction, and then again with the increased strength reading correction to see what difference there was to support the decision that was made.
- Q.** I think it is your view in your report that a slit-lamp examination should have been performed at this examination on 10 October. Are there any records or any notations on Mr Phillips' record which confirm the performance of a slit-lamp examination and what those results would be? We are at page 11.
- A.** It is unclear to me whether or not a slit-lamp examination has been carried out. It is possible. The comment 'LO both eyes' I would interpret as lens opacities in both eyes. That finding could have been arrived at as a result of ophthalmoscopy or slit-lamp examination.
- Q.** Are there any specific notations you would expect to see relating to the results of a slit-lamp examination for this patient?
- A.** When she has come back in again on a second occasion now complaining of episodes of pain following near frontal headaches I feel comment on the state of the cornea would have been important. Comment on the anterior chamber angle given that if the slit-lamp examination was being carried out, it would be an important feature to note.
- Q.** You said before in your evidence that the angle would have appeared to be more narrow on 12 September. Would that in any way have changed between 21 September and now 10 October?
- A.** No. Not substantively. This patient almost certainly had a shallow anterior chamber angle during the periods of time of examination in September and October.
- Q.** Is that something that should have been recorded or not?
- A.** It is something that should have been recorded if a slit-lamp examination had been carried out.

- Q.** Why was a slit-lamp examination so important for this patient?
- A.** As was given in earlier evidence, because of the symptoms of pain.
- Q.** It is also your opinion that there was no explanation, no adequate explanation, for the presenting symptoms. Again, it may seem to be somewhat repetitive, but I am conscious this is a separate case that the Committee have to consider. I wonder if you could just explain broadly your view in that regard.
- A.** Presenting complaint on this occasion was episodes of pain and we have a decision which was made to increase this patient's reading prescription by quite a large step. In my opinion, I can't follow the logic of increasing the reading prescription without evidence that the near visual acuity was blurred and nor would such a change in prescription be likely to be influenced in respect of the symptom of pain. If somebody has a focus problem with the eye in my opinion they complain about other things, difficulty seeing in particular, difficulty with clarity of vision.
- Q.** How central would have been an examination of visual acuity if at all, of the near visual acuity?
- A.** I think it would have gone some way towards supporting the decision that was taken. If, for example, Mr Phillips had recorded a reduction in visual acuity with this patient's varifocal prescription at near, and then found by increasing the reading addition there was an improvement in visual acuity, that would have lent some support in respect of the decision that was made.
- Q.** What, again, broadly, was your view of the record card and the quality of the records kept by Mr Phillips during this examination?
- A.** I think the omission of near visual acuity, although in the wider context of an optometric examination, may in itself if the rest of the record card is full and reasonable, may not seem to be a particularly important matter in some people's eyes. I believe in this particular instance it was important because it was the explanation behind this particular registrant's decision to make an amendment to the prescription. So I feel the omission of visual acuity is important.
- The external eye examination I also feel would have been important. There is comment here on the internal eye in respect of the lens. I believe there is an annotation in respect of the optic disc, but I am unclear about that, so there are aspects on the record that relate to the internal eye but not in respect of the external eye. One would not normally expect an external eye examination at a re-check for spectacle tolerance matters, but as expressed earlier, I believe that the symptoms went beyond this.
- Q.** You mentioned re-check both in respect of Ms Macken's case and now Mr Phillips. What actually does that mean to an optometrist?
- A.** Well, sometimes they are booked in as a 'non-tol', or a 'non-tolerance' or a 're-check'. I think the implication being that the patient is having trouble adapting to new spectacles and I would be in agreement with Dr Eperjesi that this is something that is fairly common. We get our fair share in hospital practice because of the nature of the prescriptions that we are giving out, and so it is not an unusual format of optometric appointment.

- Q.** What is the difference in these two cases then?
- A.** The difference in these two cases in my opinion is the presence of some symptoms that went above and beyond what one might reasonably expect of an optometrist in respect of non-tolerance examination in that the symptoms were not those that in my opinion could be reasonably attributed towards spectacle intolerance matters.
- Q.** Your opinion is that those symptoms went above and beyond. Would that be a reflection of the profession would you say?
- A.** I believe so.
- Q.** If this was a case scenario presented to one of your students, or as part of an optometric examination, what would be an appropriate or regulated answer as to what should have been done by the optometrist?
- A.** It may well be possible that re-checking the prescription was part of what they needed to do, but not all of what they needed to do, and that the examination of ocular structures, etc. as previously given in response to earlier questions, would be reasonable and expected.
- Q.** Expected for what reason?
- A.** Expected in that the symptoms warranted further investigation.
- Q.** Thank you. I won't touch on the points on record keeping, you touched on those earlier with Ms Macken, but the same point obviously arises for both cases. You have in front of you the expert report of Dr Eperjesi, it is at page 16 of this bundle in front of you now. Again do you have any comments or observations to make in respect of Dr Eperjesi's report?
- A.** I think we are essentially dealing with similar sorts of issues if I could speak in a generic sense, in respect of the interpretation of the symptoms and the necessity for additional examinations versus simple spectacle re-checking.
- Q.** I am grateful, Dr Harper. Thank you very much. Thank you, Madam.

Ms Hallendorff: Mr Stern.

DR HARPER cross-examination by MR STERN

- Mr Stern:** Dr Harper, could we start with your CV, because it is a little bit of a narrative if I may say so rather than setting out details of what it is that you have been involved in. As I understand it from your curriculum vitae, you registered in 1987.
- A.** That is correct.
- Q.** You then spent two years undertaking a Masters Degree.
- A.** That is correct.
- Q.** Thereafter three years doing a PhD.
- A.** Correct.

Q. Now at some stage I think you worked part time as an optician for seven years.

A. That is correct.

Q. When was that? Which years are we talking about?

A. For all of that period of time that you have just alluded to in respect of the higher qualifications.

Q. Right, so from 1987 until 1994 you worked part time as an optometrist.

A. Correct, but I would argue that I worked –

Q. I am not asking you to argue with me at the moment.

A. Can I clarify? I was an optometrist during all of that period of time -

Q. I know you were.

Mr Swinstead: Let Dr Harper just finish what he wants to say.

Dr Harper: The point I wish to make is that I was an optometrist during all of that period of time. I worked as an optometrist full time. I worked part time as a High Street community-based optometrist which is, I think, the point you are driving at.

Mr Stern: Don't worry about the point I'm driving at, just trying to understand what it is that you are saying. I am asking you this because your CV, to me anyway, is not clear. When did you work as a High Street optometrist then?

A. During the years that you have specified.

Q. Just those seven years?

A. Yes.

Q. Is that full time or part time?

A. It was part time.

Q. Right. When you say "part time", what do you mean?

A. Well, on a locum basis, so on a Thursday or a Saturday I would have gone off and worked in an independent optometrists' practice. In fact, between 1989 and 1992 I was employed exclusively by Boots Opticians.

Q. I don't really need to know the name of the company. All I am asking is, is it one or two days a week?

A. May I be permitted to expand on that answer, because it is relevant in the sense that during that period of time I was employed by a commercial organisation - not an academic optometrist.

Q. That is why I was asking about High Street optometry.

A. On that occasion, during that period of time, I would have worked probably two or three days a week in community practice.

- Q.** Thank you. Do we take it, then, that between 1994 and 2006, or 2007, you have not worked in a High Street optometrist practice?
- A.** That is correct.
- Q.** So your practice, again perhaps you can help the Committee with this, your practice in a hospital, of which you have told us 50 per cent is clinical, relates to dealing with patients who are referred to the hospital?
- A.** That is correct.
- Q.** So far as patients who arrive at the hospital, they are not seen by an optometrist, but they are seen by an ophthalmologist.
- A.** That is correct in some instances, but not in others.
- Q.** Is it right to say that the diagnosis of a patient when they come to a hospital is mostly dealt with by an ophthalmologist?
- A.** It may well be the case in many hospitals but in Manchester Royal Eye Hospital we have optometrists, including myself, conducting sessions where we ourselves conduct the primary examination of the patient and make a decision about the diagnosis.
- Q.** So are you saying that in your hospital you personally carry out the initial review of the patient?
- A.** I am not saying that that is the case for all patients attending the hospital. What I am suggesting is that in some of the clinics that I am involved in, it is the case that the optometrist, and I do one session a week at this particular type of clinic, actually assesses the new patient referrals from community optometrists.
- Q.** Right, so one session a week you are carrying out the task of diagnosing the patient from the referral.
- A.** If you like, yes.
- Q.** I am asking you, because it is not clear from your CV and I just want to be clear about it. Now you have a special interest in glaucoma.
- A.** Correct.
- Q.** You have carried out research in glaucoma.
- A.** Correct.
- Q.** I think you mentioned, although you didn't tell the Committee the date, in the year 2000 you set up the Manchester Glaucoma Referral Refinement Scheme.
- A.** Yes, I think it would be more accurate to say I was part of a team that was involved in that. Yes, that is correct.
- Q.** You were part of the team that set up this, and as I understand it, that was to set up a group of accredited optometrists with, I think as the material describes it, 'superior skill', in inverted commas I think is the way it is put. You were more highly trained and therefore would hopefully reduce the false

referrals of which there are about 40 per cent? I know that is a very long question.

A. Yes, I think that is a reasonable summary of it.

Q. When the patient sees an accredited optometrist, that optometrist would undertake the tests that the patient would ordinarily get in hospital. Have I understood that correctly or not?

A. They would attempt to refine the referral from the primary optometrist. They would undertake the tests, they are actually the same sort of tests that an optometrist in a community practice may undertake in fact, rather than going to the extent of the sort of testing that they actually might have in the hospital. I think it is actually more akin to a more extensive community based assessment.

Q. I think we can see from your CV that in 2005 you undertook the qualification and diploma in glaucoma?

A. That is correct.

Q. Your teaching. You teach graduates and undergraduates?

A. Yes.

Q. What sort of percentage of time do you spend with undergraduates?

A. Very limited. It is just a handful of lectures.

Q. A year?

A. A year – a handful of lectures a year.

Q. Right. Now, you say in your report that you have recently been an expert witness in a number of GOC cases?

A. Correct.

Q. What does “In the recent past” mean?

A. About five years.

Q. About five years, and is it just in the GOC, or has it been elsewhere?

A. In terms of attending Hearings, it has been GOC related. I have provided a few reports, a small number of reports, in civil matters.

Q. Again in the last five years?

A. Yes.

Q. In terms of Hearings at the General Optical Council, is that just for the Council?

A. Yes.

Q. Let me just ask you this – are you familiar with the CPR?

Ms Hallendorff: Can we have an explanation?

Mr Stern: I'll just see if the witness knows what it is first of all.

A. Is this some kind of trick or something?

Q. No trick.

A. The Commission for Professional Regulation, is it?

Q. No, no, the Civil Procedure Rules.

A. Obviously not.

Q. Because the Civil Procedure Rules set down, do they not, fairly clear guidance as to what an expert should include in their report? Maybe you don't know that.

A. I'll take your word for it.

Q. There is no Declaration of Independence in your report is there?

A. I am happy to verbally give that Declaration.

Q. I am sure you are, but at the moment I am just asking whether or not there is any Declaration of Independence in your report?

A. I don't believe it's stated.

Q. All right. Can I just ask you, then, to –

A. If that is an issue to be taken, perhaps I should be given the opportunity to give that Declaration now, if that is a substantive point.

Q. You will be re-examined in due course. You have given quite lengthy evidence and all matters that arose, Mr Alder can deal with as and when it is appropriate.

Ms Macken, please. Let's just deal with that particular period of time. Can I just understand what it is that you are saying, because I think we agree on one point? Let's just try and narrow it down. Is it right that you say that the tests that were carried out by Ms Macken would be perfectly reasonable if the symptoms if the re-presentation by this patient appeared to relate to spectacles?

A. Yes.

Q. So the issue between us is whether or not it was reasonable to conclude that the explanation for the symptoms was non-adaptation of spectacles?

A. Correct.

Q. I hope that helps, because we want to try and narrow in, or focus in on what it is that we are discussing. What is critical here is you have put in your report the symptoms expressed by the patient at presentation. Do you agree?

A. My report contains lots of things. I am sorry, can you repeat the question?

Q. Well, I am just quoting from your report. In addressing these questions it is important to consider the symptoms at this presentation. Obviously the symptoms of the patient are what you are concerned with.

A. Yes, I was given a number of instructions as you will appreciate, and that particular comment pertained to the items you see in bold in the report there.

- Q.** Yes, but what you have told us time and time again, perfectly properly and fairly, is that in your view the symptoms presented by the patient would have caused a reasonable optometrist to have carried out further tests.
- A.** Yes.
- Q.** Right, so the symptoms are important.
- A.** Yes.
- Q.** Right. That is all I am establishing. Can we just look back, because I don't think we spent any time looking at 12 September 2005, which was a full sight test? It is page 12 in one of the bundles. I hope it is page 12, yes. It has the date stamp of 12 September 2005. Do you have that?
- A.** Yes.
- Q.** Now, perhaps you will take it from me at the moment that that was a sight test carried out by the experienced owner of the practice. In fact, you would know that because you saw his letter, I think. He was the owner of the practice, Mr Davies.
- A.** Yes, Mr Davies.
- Q.** This is obviously nine days before Ms Macken sees the patient on 21 September 2005.
- A.** Correct.
- Q.** So 12 September there is a full sight test carried out. Yes?
- A.** Yes.
- Q.** At that sight test, it is right, isn't it, that there was no abnormality detected or any problems recorded?
- A.** No abnormality detected, but a big change in prescription for the benefit of the patient which is why Mr Davies duly went ahead and prescribed some new spectacles.
- Q.** Yes, we are going to come on to that, but all was normal, was it not?
- A.** Insofar as the comments written on the record card are concerned, yes.
- Q.** Well that is all we can go on for the moment. That is all that Ms Macken would have seen. Yes?
- A.** Yes.
- Q.** There is, as you rightly point out, an increase in the prescription for the right eye of +1.5. Do you agree?
- A.** The prescription has – depends on – increases and decreases. This patient has become less long-sighted. There is –
- Q.** Forgive me, I am not an expert. It has changed to the tune +1.5?
- A.** Yes, thereabouts, yes.

- Q.** Thereabouts, and so far as the left eye is concerned, let me just make that clear for those who, like me, struggle with these things. It went from +1.25, correct?
- A.** Yes.
- Q.** Which we can see on the left hand side under "occupation".
- A.** Yes.
- Q.** It says, "Right +1.25", yes?
- A.** Yes.
- Q.** Then it went to -0.25?
- A.** Correct.
- Q.** Right, so that was a change. In the left eye it went from +1.50 to + 0.50.
- A.** Correct.
- Q.** That is the change of the one diopetre?
- A.** Yes.
- Q.** So there was a bigger change in the right eye?
- A.** Yes.
- Q.** Mr Davies recommended a further test in six months' time.
- A.** Yes.
- Q.** We can see that he carried out an ophthalmoscopy on the left hand side. Discs and macular healthy. Yes, under "external"?
- A.** Yes.
- Q.** We can see that in relation to media he carried out the slit-lamp test?
- A.** Yes.
- Q.** C/D 0.2, yes?
- A.** Yes.
- Q.** He has written 'S lamp', so that is slit-lamp test there. We can see underneath that that he has written "nuclear sclerosis", cataract lens changes, yes?
- A.** Yes.
- Q.** As I say, he recommended a re-test in six months. Just on the right hand side of the page, page 12, about half way down, can you see "Add for reading +2.25"?
- A.** Yes, I can see that.
- Q.** Now on 21 September, so that is page 11, the patient is arriving, perhaps again you will take it from me, there is no appointment. The patient just came back to the practice. We will hear in due course what is in the diary in relation

to that. The patient came in for a fitting, right? Maybe you haven't seen the diary. Have you seen the diary?

A. I believe I did catch sight of the page.

Q. As I said, there shall be evidence about that in a moment.

Mr Alder: Is that something that should be given as evidence to Dr Harper now if you are going to refer to it?

Mr Stern: Yes, certainly. I think we have copies. Shall we at the moment just give the September date? You may as well have the October dates, as we have got them copied so that the Committee have them. That will just make life easier. [*Documents distributed*]

Mr Swinstead: Mr Alder, have you seen these?

Mr Alder: Sir, I saw them for the first thing this morning.

Mr Swinstead: You have copies?

Mr Alder: I have a copy, thank you. It seems little point asking Mr Stern at this stage to make the application that we have already been through today, and I assume he is covering the same ground.

Mr Stern: I am afraid the date is not entirely clear on this copy. September 2005, it has at the top "Sasha pm only". That is Ms Macken, and then we can see at the bottom of the page, although it is scribbled out, I won't name the patient, Dr Harper. It says "calling for fitting pm". Can you see that?

A. Yes.

Q. Then underneath that "Ask Sasha".

A. Yes.

Q. Right, so I don't know whether that helps you or doesn't help you, but anyway there it is for the moment. Now the patient reported on 21 September that the varifocals that had been prescribed, we can see "worn various previously" and then it says "DV" and then the reduced arrow. Yes?

A. Yes.

Q. That decrease, or sign, can either be a decrease or a blur. For whatever reason it can be a decrease in the vision which may be as a result of the sight not going terribly well, or the blur.

A. It implies the patient has said something to indicate that their distance vision isn't clear, yes.

Q. Now if you can see, obviously the patient did not get the spectacles that were prescribed by Mr Davies on 12 September. She would not have got them on the day that she actually attended the practice. What is written there is that the patient has had them for four days. Can you see? Four days and the patient had only been wearing them for two hours a day.

- A.** Right.
- Q.** Right, so the patient was having a problem obviously, if that is right, in managing wearing the spectacles.
- A.** Yes.
- Q.** She had headaches when she was wearing them. Yes? Just imagine this position that I am putting to you, if you will, and she had had a single incident of pain in the right eye for about five minutes.
- A.** Well, she has had headaches. We don't know whether it was when she was wearing them or not.
- Q.** That is why I say you have to accept from me for the moment what I am putting to you. Okay? Headaches when wearing them and a single incident of pain in the right eye for five minutes. Yes?
- A.** That is what's written on the record card.
- Q.** That's what is written. Of course, obviously you can't say, because you weren't there.
- A.** Exactly.
- Q.** But I have to put to you obviously various scenarios. There are other scenarios have been put to you as well. Now you agree that headaches and blurring are common symptoms complained of by patients with new spectacles.
- A.** I agree that headaches and blurring can be common symptoms, yes, of non-tolerance.
- Q.** Yes. Patients come in all the time. Obviously you haven't been in a High Street for some time, but patients do come in, do they not, is that your understanding?
- A.** Can I just clarify? Patients come in non-tolerance in the hospital I service very commonly, so non-tolerance and spectacle adaptation problems are something that I deal with quite commonly.
- Q.** But these are people who have something over and above –
- A.** Not always. Not from a refraction point of view. There are many eye hospital patients who attend the hospital for other reasons unrelated to focus problems that happen to have a sight test in the hospital.
- Q.** Now you say in your experience, patients do not normally complain of pain in your experience.
- A.** That is correct.
- Q.** But sometimes they do. Then it follows that if they don't normally, then sometimes they must do.
- A.** I can only give you my opinion, which is out of the non-tolerances of patients that I have seen, pain was not a symptom they have reported.
- Q.** Right, so why is it in your report that they don't normally?

- A.** Because that is my personal experience, which was all I was trying to communicate to you. If I said 'never' it would imply I had some specialist knowledge and insight into all cases of non-tolerance, which I clearly don't. I don't believe there has been a scientific investigation into non-tolerance, so I couldn't exclude the possibility that somebody somewhere has found that pain is associated with spectacle non-tolerance.
- Q.** Well, just so we understand, so far as you are concerned, in your position in the hospital, you have never had a patient come in complaining of pain of any description as a result of having new spectacles?
- A.** I believe that is correct, yes.
- Q.** Right. Therefore it may be the experience of others, you would accept, is very different from yours?
- A.** It could well be.
- Q.** Have you any reason to believe that Dr Eperjesi would not be accurate in that regard or had a different experience in that regard?
- A.** That is for Dr Eperjesi to comment on. I am not sure I could comment on that particular question.
- Q.** Now, particularly, varifocals are spectacles that can cause a difficulty to a patient in that regard. Do you agree?
- A.** In terms of tolerance, yes.
- Q.** In tolerance, because the fitting is crucial, is it not?
- A.** Yes.
- Q.** Because if the centres are too high then this will create a blurred vision in the distance, will it not?
- A.** Yes.
- Q.** There are different types of varifocals?
- A.** Yes.
- Q.** Because you made the point before that the patient had had varifocals in the past, but we don't know the type of varifocals. There are different types, are there not?
- A.** There are.
- Q.** So that is a factor as well, do you agree?
- A.** It's a factor in what sense?
- Q.** Well, it is a factor to take into account when the patient comes back and sees you and is complaining of blurred vision.
- A.** If the patient comes back with symptoms that are those relating to non-tolerance and they wear varifocals, then the type of varifocals they wear may well be relevant to their non-tolerance to the matter, yes.

- Q.** Yes, but your point as I understand it, is because you have never experienced this question of a patient coming in and saying, 'I feel pain as a result of spectacles' –
- A.** Pain in one eye.
- Q.** Well, okay, you have never had a pain in either eye, so it doesn't really matter if it is one eye or two eyes, but because you have never had that, it is your view that further tests should be carried out. That is what it comes to, isn't it?
- A.** Well, I believe that pain has a range of other ophthalmic explanations. They needed to be explored.
- Q.** Yes, but we are not at a seminar here. This is a disciplinary hearing, and the test really is whether or not you are saying that, bearing in mind the symptoms that we have here, and let me just run through them for your sake and for mine. We have a patient who is unable to wear glasses for more than two hours all right; on the record card, yes?
- A.** Yes.
- Q.** New varifocals with a substantial change in the prescription.
- A.** Yes, which if anything you would associate with an improvement in visual acuity, which is documented as 6/9, 6/6.
- Q.** A sight test nine days earlier and one episode of pain in the right eye.
- A.** As is communicated on the record card, yes.
- Q.** Are you saying that no reasonable optometrist could possibly have come to the conclusion that this may be evidence of non-tolerance of spectacles?
- A.** I don't believe the patient reporting pain in their right eye, with headaches, talking about a drop in distance vision, the vision acuity is recorded as being better with this correction with what they came in with ten days earlier, I don't believe that spectacle non-tolerance was sufficient an explanation.
- Q.** That is not really the test, because we are not, as I say, on a seminar here, and whether or not something should have been done a little bit better or done a little bit worse. The question is, are you saying that no reasonable optometrist could have come to that conclusion?
- A.** What I am saying is I would expect an average competent optometrist to have considered some other possible explanation for the symptom of pain, yes.
- Q.** I appreciate that is what you are saying.
- A.** Well, I believe that has answered your question, Mr Stern.
- Q.** Well, bear with me because it is not for you to object to questions. If there is an objection to the question, then obviously we can argue it amongst ourselves.
- A.** I am trying in good faith to respond to your questions.
- Q.** It's a simple question, really. Yes or no? Are you saying that no reasonable optometrist could have come to the conclusion that the symptoms presented

in the way that I have described them amounted to non-tolerance of spectacles?

A. I am saying that I do not believe the symptom of pain in one eye can be attributed to spectacle non-tolerance. Therefore I believe it would be reasonable to expect an average competent optometrist to be looking for something other than spectacle adaptation problems in this certain circumstance faced with this scenario. I believe that answers your question.

Q. Well, I don't know whether it does or it doesn't, but I will leave it there. I have asked it three or four times and I don't see much point in asking it again. Let me just go back then, please, to 21 September. Do you accept you can get pain from the frames as well as the lenses?

A. Not in the eye usually. You might get pain on the bridge of the nose, pain on the temples, but pain in the eye from spectacle frame fitting is not something, again, that I have personal experience of.

Q. I think it is more, I think it may be my fault, that the fitting of the lens, that is to say the position of the centres.

A. I believe the symptoms would be more likely to be blur, or possibly double vision.

Q. Now just dealing with primary angle-closure glaucoma, that is, as it says in the report, and I don't want to go through it again, it is very rare.

A. Could you repeat the question?

Q. Did I say it wrongly? Sorry - primary angle-closure glaucoma.

A. Yes, I am in agreement with Dr Eperjesi. It is rare, yes.

Q. I think he has put it at – well, it is not him, he has taken it from the text book, 0.6 per cent of the population.

A. I wouldn't disagree.

Q. The primary angle-closure glaucoma can also be further categorised, can't it, into acute, intermittent and chronic?

A. That is correct, yes.

Q. Do you agree that intermittent glaucoma of this type, I won't say it all over again, is even of course more rare than 0.6 per cent? It must be.

A. It has to be by definition, yes.

Q. Yes. So far as the notes are concerned in relation to 21 September, if it is right that it was reasonable for the practitioner to come to the conclusion that it was spectacle tolerance, then the notes are adequate, I think you have already said that.

A. Yes, if it was a re-check and the understanding was that the symptoms related to spectacle tolerance matters, then the notes and the tests conducted are reasonable.

Q. The patient was asked to give them a further two weeks, give the spectacles a further two weeks as we can see.

- A.** Yes, that is correct.
- Q.** Half way down, that is 2/52, that is two weeks, not two days.
- A.** Correct.
- Q.** Would you agree that if the patient had intermittent primary angle-closure glaucoma it would not be reduced or disappear if the patient wore her old spectacles?
- A.** Correct.
- Q.** Right, would you turn now, please, to 10 October - Mr Phillips. The patient came back, I accept the handwriting isn't that clear, but if you look at page 10. Let me try and help in this regard. The patient came back and reported three episodes of pain after reading, and also frontal headaches. This is in the top left hand corner of 'Symptoms and History'. Also just below the age, and crucially, I suggest to you, the patient indicated that she had not experienced any discomfort with the old prescription. Now, maybe you couldn't read it, and that would be perfectly fair.
- A.** I can't read it, actually.
- Q.** Right. It says "prefers old prescription for near".
- A.** Right.
- Q.** I am doing my best to translate that for you, which is just to the right underneath the age. You haven't referred to that in your report at all, that particular passage, and maybe you will say it makes no difference, I don't know.
- A.** No, I think in fairness I couldn't interpret that comment.
- Q.** No, but having now interpreted it, if I am right about that, and we will hear evidence obviously about that, but if that is right, if a patient is saying, "Well, in fact I don't get this problem when I wear my old specs", then – I am paraphrasing, you understand – if that is said to the practitioner, again do you think a reasonable practitioner could come to the conclusion that it was as a result of non-tolerance of spectacles?
- A.** Yes, if they are saying they have a problem and the problem goes away when they wear their old spectacles, then of course.
- Q.** Right. Now, in relation to this patient there is no reference to blurred vision or that being only in the evening, is there?
- A.** No.
- Q.** If the visual acuity was tested, and I accept there is no reference to it, but perhaps you will accept that that may be the evidence, and that was normal. Not everybody does record normal visual acuity. Do you agree? Near visual acuity I am talking about.
- A.** I think distance visual acuity has more weight on a record card and near visual acuity in an otherwise full record card, and the omission thereof is not something that necessarily would cause somebody to lose too much sleep over, no.

- Q.** No, but if it was not done you have already told us that that was important. If the evidence is that that was done but just not recorded, you would not have a difficulty with that?
- A.** No.
- Q.** If it were unchanged from the previous visits, the intra-ocular pressures were well within the normal range, weren't they? They were 13, we can see.
- A.** Yes.
- Q.** The patient has said that there was no, it is bottom left hand corner, CT 13 right and left and in brackets it looks like 300, but it is 3:00 pm, the time it was done. So the patient has said that she did not have a test, but obviously this is a contact tonometer which is perhaps unusual amongst optometrists these days.
- A.** It's probably less common, yes.
- Q.** They are more reliable some may think, but I won't go into that.
- A.** Is that a question?
- Q.** No, it's a comment.
- A.** Could you ask questions?
- Q.** He carried out the assessment of the motor ocular balance, is that right?
- A.** Ocular motor balance, that is correct.
- Q.** Thank you. Ocular motor balance and what is the purpose in that?
- A.** It is to establish whether or not the patient is suffering from a binocular or an imbalance between the way the two eyes are coordinated, as it were, that might be explanatory in respect of the symptoms.
- Q.** Right and they were normal?
- A.** I can't fully interpret what is written, but I believe that the comment is indicative of a normal outcome.
- Q.** Right. Ophthalmoscopy was carried out, as we can see lens opacities 'BE', both eyes.
- A.** Yes.
- Q.** Just below that, although I appreciate you may not have realised this because the copy is not brilliant, there is Fuchs' both eyes.
- A.** I am afraid I couldn't attempt that at all. It doesn't look like an 'F' on my copy.
- Q.** Well, as you can see the left hand side is missing. If you look at the top, the word is 'ptoms', as opposed to 'symptoms'.
- A.** Yes indeed, yes.
- Q.** So again if that is right, you didn't see the original. You didn't see the originals?
- A.** No, probably these copies.

- Q.** Right. If it is right, and the record there shows Fuchs' dystrophy in both eyes, then obviously it is clear, is it not, that the practitioner looked into the patient's eyes with a slit-lamp?
- A.** Yes.
- Q.** And obviously observed the cornea.
- A.** Yes.
- Q.** Now he concluded that the problem with the patient was a non-tolerance of the new spectacles - the varifocals. Yes?
- A.** Yes.
- Q.** Because he has written that as you can see there. It is in the right hand side, the lower part of the section, "return lenses as non-tol". Can you see that?
- A.** Yes.
- Q.** Then it has got 24 October 2005 'non-tol', it looks like "near vision problems", and then "2 pairs".
- A.** Yes.
- Q.** So that was the conclusion that the practitioner came to.
- A.** Can I just clarify? I appreciate I am not supposed to ask questions, but I am wishing to clarify whether or not that is the conclusion that was drawn on the examination on 10 October or whether there was some subsequent correspondence or communication that resulted in that particular comment. Because obviously 24 October, self-evidently, is after 10 October.
- Q.** Absolutely. At the moment I can't obviously answer that because you are going to have to hear evidence, but I don't think any evidence impacts there, let me put it that way. Well, it may be, we don't know, it may be that the lenses were collected on 24 October, one doesn't know because new lenses were then prescribed as you have already told us on 10 October.
- A.** My understanding is from all the evidence presented to me, which includes the response of the registrant to the GOC, new spectacles were prescribed, yes. I am not necessarily getting that information from the record card here.
- Q.** Well, I think 'DV B105' and 'NV B185', or something like that.
- A.** Yes, again I don't know whether that relates to 24 October or whether your comments about new spectacles are relating to 10 October.
- Q.** Right, again we will have to hear evidence, but let's assume as you say from the explanation that has been given that new spectacles were prescribed on 10 October.
- A.** Yes.
- Q.** We don't know when they were received, all right? Obviously some time down the line, not on 10 October, because two pairs, and the –
- A.** Sorry, can I just interrupt again, please. It is just that I am still unclear whether on this first occasion, on 10 October, a decision was made to re-

prescribe varifocals, and subsequently separate pairs to be prescribed. So that is a matter for the registrant to comment on.

Q. I think it probably is. In any event, we can see that reading prescriptions were prescribed at from 2.25 to 3.25.

A. That appears to be so.

Q. The 3.25 is almost the same as the original spectacles that the patient came in with. I am glad I have got it right, because Mr Rowan is nodding, so I have obviously got it right. The original spectacles that he came in with?

A. Near, yes.

Q. So the spectacles that were being prescribed by Mr Phillips were back to the same reading prescription that the patient had had prior to 12 September?

A. Yes, very similar.

Q. Now you criticise Mr Phillips on two grounds at page 56 as I read your report. It is in the top paragraph. You say that "he failed to undertake the necessary external eye". I presume you mean just an assessment of the external eye. Just looking at it do you mean?

A. I would have meant the slit-lamp examination. Remember at this stage I did not have knowledge of the fact that there was a comment on Fuchs' dystrophy.

Q. Right, so that goes, does it?

A. Clearly a slit-lamp examination is highly likely to have taken place, yes.

Q. Assume for a moment, obviously you can't say at the moment whether it took place or not, but if it had taken place then your criticism goes that the external eye was reviewed?

A. The criticism that the test was undertaken goes.

Q. Yes, and the anterior segment assessment, that would not need to be done, would it, if you concluded that it was a spectacle adaption problem?

A. If you had concluded that it was a spectacle adaption problem, then that may be so, but of course in carrying out a slit-lamp examination, I would expect an average competent optometrist to have noticed that that patient had a shallow anterior chamber angle.

Q. Yes, if it had been carried out, yes. Now we know that the pressures are on the low side.

A. Yes.

Q. We also know that Mr Davies on 12 September found the CD 0.2, which was a normal range.

A. Yes.

Q. I just want to ask you, please, to look at your report in relation to Ms Macken. First of all, if you would look on page 56 - if you look in the middle paragraph, half way down the middle paragraph you say, "From the symptoms recorded

by the doctor assessing the Patient A on presentation at the Cardiff Eye Unit". Do you have that?

A. Yes.

Q. You then recite what is in the patient record by saying, 'Patient A presented having noticed a sign of red right eye about a week before'.

A. Yes.

Q. Is that a misinterpretation as I think you have already said of 1/7?

A. That is correct.

Q. So it is an easy mistake to make.

A. When it comes to that particular point of 1/7, yes, I believe, clearly, I made it.

Q. Yes, and I have no doubt that the same comment that you made about notes one can make about reports coming before professional bodies. You would consider them to be extremely important?

A. Yes, I think accuracy in these reports is of course very important.

Q. Yes. I think you made the mistake again if I may say so. If you look at page 57, the top of the page, again the second sentence, "The symptoms recorded by the doctor assessing Patient A on presentation, noticed a sign of red right eye about a week ago". Do I have the right page, I hope I do? Page 57. Internal numbering of the report, page 14.

Ms Hallendorff: It is Mr Phillips' documents.

Mr Stern: Mr Phillips, yes, I am sorry.

A. Mr Phillips.

Q. I am sorry.

A. Yes, the comment you just alluded to as far as Ms Macken is concerned, the error is repeated in the other report, yes, that is correct.

Q. Yes. No doubt you read these through when you signed them in July?

A. I did read the report through, yes.

Q. Can I just ask you about Fuchs' dystrophy. Fuchs' dystrophy can be described by somebody, by an optometrist, as being minor corneal changes in this patient?

A. Yes, I think that is reasonable.

Q. So where in the letter they have got "minor corneal changes (Fuchs' dystrophy)", that is obviously an explanation of what Fuchs' dystrophy is. Did you not read it as that?

A. The comment I make in respect of Point 2 on page 58 is with reference to the annotation on the record card. I believe that in the representation to the GOC by Ms Macken and Mr Phillips, the representation by Ms Macken makes reference to the notes of Mr Davies which are described as detailing early lens changes, minor corneal changes, Fuchs' dystrophy and CD ratios of 0.2

with discs appearing, etc. etc. My comment was merely that I did not see on the record card an examination of ocular structures indicating Fuchs' dystrophy. You have now of course in respect of the examination of Mr Phillips indicated that he did, indeed, include a comment on corneal changes but there is an absence of comment on corneal changes in respect of the record card of Ms Macken.

Q. Yes, but was she saying she has reviewed Mr Davies' notes? She is saying what is in Mr Davies' notes.

A. Yes, but she goes on to say, "I concluded that these notes were accurate and still relevant". That would imply some degree of examination to conclude that. How can you conclude that somebody's records are accurate unless you observe the same ocular structure yourself? You cannot just assume that somebody's eyes remain the same.

Q. But she is not saying this. She is saying the notes were accurate and that they were still relevant. They were still relevant to her consideration nine days later.

A. They may well be, but the point I was making was merely that the basis of that comment was unclear to me at the time I wrote my report. I was making a comment about what was said in a representation to the GOC about somebody else's notes being accurate and relevant and highlighting the fact that it was unclear to me reviewing the evidence as to the basis of that comment in that it was not clear to me that there was an examination of the eye to support the accuracy and validity of the comments.

Q. All right. This is not expertise. This is your interpretation of page 51 of the letter.

A. There is no comment on the external eye of Ms Macken's record card. Therefore what is the basis of saying, 'I conclude that somebody else's record in respect of corneal changes is accurate'?

Q. Well, let me just tell you what the allegation is, because that is what we are here to believe. The allegation is that in Ms Macken's representation she referred to Patient A's previous records indicating minor corneal changes which is inaccurate. The previous records do indicate minor corneal changes.

A. Does Mr Davies comment on the cornea? If I just go back –

Q. I thought we said Fuchs' dystrophy was essentially the same thing.

A. Well, if I could just refer to it.

Q. Of course.

A. Yes, there is indeed a comment on Fuchs' dystrophy, and can I clarify the time I wrote my report, remember this is write down C/D, internal eye examination, I had no knowledge that this said Fuchs' dystrophy.

Q. No, you are looking at Mr Phillips now, aren't you?

A. I beg your pardon. Sorry, so, yes, in Mr Davies examination, in other words, the record card that Ms Macken had available to her on her examination on 21 September 2005 does not describe an examination of the cornea. It

describes a patient's ocular history of Fuchs' dystrophy which is distinctly different from an optometrist examining the cornea and finding Fuchs' dystrophy or minor corneal changes.

Q. What about C/D 0.2?

A. That has nothing to do with the cornea.

Q. Nothing to do with the cornea?

A. C/D of 0.2 is in respect of the optic disc.

Q. Right, so that has nothing to do with it. Cataract and lens changes, that has nothing to do with it?

A. Nothing to do with minor corneal changes, so I stand by the comment I made in my report.

Q. So that's it, is it? So she could not conclude that the notes were still accurate and relevant although that is not the allegation, but that is your point anyway.

A. The point I am making is I did not understand the basis on which she had made the comment because there was no evidence of an examination of the external eye.

Q. I see. Well, it is always nice to get the understanding of what the case is at this stage. All right; thank you very much.

Ms Hallendorff: Mr Alder, would you like to make any comments?

Mr Alder: It is only necessary to make one very brief comment. It may have been an error of mine in the letters from the Council instructing you, Dr Harper. Are you able to confirm that you have prepared your reports in respect of both cases on an impartial basis?

A. Correct.

Q. Thank you and your view to your mind is a balanced one, do you suggest?

A. Absolutely, I stand by the comments I have made. Clearly there is an error about 1/7, but I have made the report in good faith in the interests of assisting the Committee in making the right decision about the registrants.

Q. I need to take that one stage further, I suppose. Have any of the points made to you in any way changed your opinion which is set out in your two reports of July 2006?

A. No, there is a comment on Mr Phillips' record card about the association of the symptoms going away when wearing the spectacles that mitigates to some extent the decision made to try to change the patient's prescription. He is obviously making a link and I did not read that comment and did not make the link. I could not decipher what was written.

Q. I am very grateful, Dr Harper. Thank you for your time. I wonder if you could wait there, though, because it may be that the Committee have questions for you. Thank you.

Ms Hallendorff: Let's start with our professional members. Mr Reily, would you like to ask any questions?

Mr Reily: No.

Ms Viner: No.

Mrs Huka: Just one question, please, Dr Harper. In the question put to you by the Council with regard to a reasonably competent optometrist, I understood your reply to suggest that the standard used in a hospital would be a different standard to the one used by a reasonably competent optometrist. Is that right or not?

A. No. I think there was possibly a question from Mr Stern that may have alluded to a difference in standards, but no, I don't believe in any of the responses I made in respect of the case that is being discussed I was giving a viewpoint of anything other than what I would expect of an average competent optometrist.

Q. Would that be the same in a hospital and in a community setting?

A. It depends on what the optometrist is doing in the hospital. Some of the roles that an optometrist undertakes in a hospital are comparable to some of the tests and activities undertaken in primary care optometry, but sometimes the optometrist in the hospital has an extended role and does take on other responsibilities and duties, carries out tests and procedures, and one may well expect a different level of expertise and a different standard to apply. Of course they are not carrying out a sight test as per the sight testing regulations, so the matter is different.

Q. But if the tests are the same, would the standards also be the same whether it be in the hospital or in the community?

A. An optometrist in the hospital would not be undertaking an eye examination as per the GOS regulations and the sight testing regulations, so they would be involved, for example, in aspects of patient care which would involve a higher level of care in some instances in terms of part of the activities that we undertook.

Q. Fine, thank you.

Ms Hallendorff: Mr Baldwin, do you have any questions?

Mr Baldwin: No, thank you.

Ms Hallendorff: May I ask our Legal Adviser?

Mr Swinstead: No, I have no questions.

Ms Hallendorff: Mr Stern, do you have anything you want to say? You have nothing further to ask him? Thank you very much.

[Dr Harper stands down]

Mr Alder: Madam that concludes the evidence.

Ms Hallendorff: Thank you.

Mr Stern: Madam, in ordinary circumstances, it would probably be more helpful to call Ms Macken first bearing in mind she was first in time, but I am going to ask to call Mr Phillips first and the reason is related to health issues in relation to his wife who has had a transplant not that long ago and so he wishes to go back home to obviously be with her. He means no discourtesy if he doesn't attend tomorrow. That is the reason. He originally did not intend to come in any event because of the difficulty with his wife, but he has been persuaded by those instructing me to attend, so he is here, but you will appreciate the personal inconvenience that that causes. So I don't know if there is any objection by anybody?

Mr Alder: No, no, of course.

Ms Hallendorff: There are no objections.

Mr Stern: Thank you very much then I will call Mr Phillips. I should just say that Ms Macken has no objection either. Come forward please.

**Mr Wilfred Hugh PHILLIPS called and sworn
Examined in chief by MR STERN**

Q. Your full name, please.

A. Wilfred Hugh Phillips.

Q. Now I think you graduated from Cardiff University in 1963.

A. Yes.

Q. Would you just tell us briefly your history of work?

A. I joined my father's practice straight from college and we expanded the practice for a few years when my father prematurely died and I continued always in the practice. I have worked for the hospital, in the hospital as a specialist contact lens practitioner. I followed my father in that instance, and I did until, I can't think of the dates, many a long year practising specialist contact lens. Also I was accredited by the Ophthalmology Department to carry out diabetic checks.

Q. I think you also fitted babies with contact lenses as well?

A. Yes, under general anaesthesia, obviously.

Q. At the hospital?

A. At the hospital.

Q. I don't want to embarrass you, but from 1969 through to 1992?

A. Yes.

- Q.** At the time your father's practice, or father's business, I think developed into having ten practices?
- A.** Yes.
- Q.** So it was a successful practice?
- A.** Yes.
- Q.** I think you were the secretary for the LOC for 20 years?
- A.** Yes.
- Q.** And also sat as the optical member for the Family Practitioner Committees for ten plus years?
- A.** Yes.
- Q.** Were you President of the South Wales Optical Association as well?
- A.** Yes.
- Q.** I think you were also a member of the Welsh Optical Committee involved in talking to the Welsh Office on behalf of the optometrists in Gwent?
- A.** Yes.
- Q.** Since 1992, where have you worked?
- A.** I worked for about ten years on a consultant basis for my old practice on a time decreasing scale to suit my personal circumstances. Thereafter, I semi-retired in 1992 and I fully retired in 2002, but in a conversation with a friend which led me to believe that Mr Davies was in somewhat difficulty in getting professional help up in his practice, I was persuaded to come out of retirement - I kept my registration with the GOC and my membership of the OP - and I did.
- Q.** I think you were working was it two days a week for him at the time of the matters we are concerned with?
- A.** Yes.
- Q.** I think you have now retired completely for reasons I obviously don't want to go into, but are nursing your wife?
- A.** Yes.
- Q.** Now this patient, Patient A, did you see her on any other occasion than 10 October 2005?
- A.** No.
- Q.** Tell us, please, if you would take up the patient record card, or a copy of it, that we had for 10 October. It is page 10. Could you help us please with what the patient arrived at the practice for?
- A.** She had an appointment. I think you have a copy of the appointment book. She wasn't what some people would call a 'walk in'. She had an appointment and she was given a full appointment which was due to take half an hour or whatever. It is in the appointment book.

- Q.** Yes, we can see a 2.30 pm appointment.
- A.** Yes and R/C is re-check probs.
- Q.** What is your practice, or has been practice over many, many years in relation to a patient, when a patient comes in?
- A.** If they come in as a new patient, you take them as a new patient, you start from scratch and you work your way through the basic things to do, and you do them. If that in your considered opinion resolves what they are complaining about, you make a pair of spectacles or whatever that is required to satisfy their complaints.
- Q.** First of all I should ask you this – do you remember, do you have an independent recollection of what is now nearly two years?
- A.** No I don't, I am sorry.
- Q.** Could you help us, then, with your notes?
- A.** Yes. It says three episodes. It is my spidery writing, I accept. Three episodes of pain after near. Prefers RX near. Prefers the old prescription for near frontal headaches.
- Q.** Doing the best you can looking at your note now, what was your understanding of what it is that you recorded there in terms of her complaints?
- A.** She was complaining about the prescription that she had that Mr Davies had given her a few weeks before and the problems revolved pure and simply around the reading prescription.
- Q.** What about under the age, about the old prescription?
- A.** Prefers old RX. Prefers RX - that is prescription, near. So I don't remember. She had obviously said to me that she had experimented quite understandably and had reverted to her old prescription, that which she had had prior to seeing Mr Davies a few weeks previously and that had resolved the problems, otherwise I would not have written 'prefer'.
- Q.** The headaches. The episodes of pain after reading in the frontal headaches, were they associated with the new spectacles or were they independent of the new spectacles?
- A.** No, they were associated with the new spectacles.
- Q.** What did you do, then? Just run us through the examination as it appears on the card.
- A.** I started. I looked at the fundus with the ophthalmoscope.
- Q.** I am just going to ask you to just pause a moment, because you will appreciate not everyone is an optician here, least of all me, so just explain what it is that you did.
- A.** I looked at the back of the eye, sorry, with an ophthalmoscope. I confirmed, or reconfirmed that the cup disc C/D was 0.2 or at least thereabouts. It is an assessment; it is not a specific measurement as is measuring the intra-ocular pressures, for example.

- Q.** Do we see the 0.2 there?
- A.** No, you don't. You see it on Mr Davies', bearing in mind that this is not a brand new patient. This is a re-check and I am just reconfirming what I considered to be a potential problem, and I took that, having looked at it, it was 0.2.
- Q.** So no difference from Mr Davies'?
- A.** No. I wasn't getting a particularly good view of the back of the eye so then I had a look with a slit-lamp to see why I wasn't getting a good look at the back of the eye. I then confirmed that she had lens opacities both eyes. That is LOBE. I then confirmed, and that would explain part of the difficulty in seeing the back of the eye, or it may have totally, and then I looked at the cornea to see that yes, she had minor corneal changes in Fuchs' dystrophy. That explained why I couldn't have a full view of the back of the eye. I then decided I would check the prescription, the spectacle prescription, which I did. Checked the muscle balance to be sure that she didn't have any double vision which she was suppressing, not reporting, but suppressing, which would cause headaches, keeping in mind that she did complain. This is what the record says, 'frontal headaches'. All her problems reported to me were revolved around reading, and particularly the reference to 'prefers old prescription near'. I then adjusted the reading prescription, the reading addition, rather, very closely allied to the original prescription.
- Q.** I think we just went through that with Dr Harper, so I need not go through those figures again.
- A.** Yes. At that stage because it has been my custom and practise to use an applanation tonometer on my routine for as long as the Perkins, which is the hand held instrument for taking pressures, because keeping in mind that I moved from practice to practice when I was in full time, that was my instrument which I retained, which I took when I was doing locum. I didn't rely on Mr Davies – he had a puffer, what the public consider a puffer. I don't like that procedure.
- Q.** That is the non-contact tonometer to measure the intra-ocular pressures in the eye?
- A.** Yes. I don't like that procedure done on me, so I have never inflicted that on patients.
- Q.** The contact tonometry - how does that work?
- A.** It works by instilling in this instance a local anaesthetic, and I tell the patients. Every time I have been doing it for - I don't know - twenty or twenty five years, as long as the Perkins tonometer has been in existence that I am now going to put some drops in your eyes. It won't affect your eyesight, so that I can assess your pressures. That is why I do it afterwards, not at the same time or coincidentally or in sequence to using the slit-lamp, because having touched the cornea you will undoubtedly distort it, if only momentarily. You will distort it, and therefore it will in essence influence the spectacle prescription which you do afterwards, but I don't do it afterwards.
- Q.** So you do the spectacle prescription first, and then do the contact tonometry?

A. Yes.

Q. Does that involve putting your chin on a sort of –

A. No. No, when putting your chin on the rest, you can view an applanation tonometer by putting your chin on the slit-lamp, but there is an addition to the slit-lamp which you put in a slot which you do exactly the same that I do, but it is a hand held. Mr Davies doesn't have that particular piece of equipment in his Cardiff practice.

Q. What about the near visual acuity? Did you test that? What is that, first of all? Just explain what that is.

A. Well, it is the standard of vision that the patient achieves for reading.

Q. How do you test it?

A. In Mr Davies' instance, he had an internally illuminated chart with letters on it, printed, Snellen letters, and it is graded usually from, I think it starts at N5 at the top and works out at N10 at the bottom, N10 being larger print.

Q. Did you do that with this patient?

A. I do it with everybody. That is a piece of equipment that Mr Davies has in order to allow the patient – it is a standard piece of equipment, in fact it is what I used to use when I had my own businesses.

Q. Did you make a note of it or not?

A. No.

Q. Why not?

A. No reason, I just didn't make it. It was normal. The distance visual acuity is recorded there above and it didn't vary from any previous visual acuity, distance visual acuity and because it was normal, no, I didn't record it.

Q. So what did you do after that?

A. I then left instructions because it was the possibility that her non-tolerance to the prescription was due to the significant myopic shift, that is as a result of developing lens opacity in both eyes, there is an initial movement to the myopic end, so if you start off, if your natural lens is opacity free and you were short sighted, when you develop lens opacities, you become more short sighted. The same myopic shift applies if you are long sighted previously which is what Patient A was, she moved in the myopic direction.

Q. Can you just have a look at the right hand side of the page? We can see the first pair, it has got 'vari' and it has been circled. Is this your handwriting?

A. No.

Q. That is not your handwriting.

A. No, I left instructions because I considered it to be, and in fact I believe – yes, in Ms Macken's record again on the right hand "return if probs, possibly separate", means if problems with Mr Davies' varifocals she considered it might be beneficial if Patient A didn't have varifocals in future and at that

point, at my point, I took the opportunity to instruct the dispenser to make two separate pairs. What he did, I don't know, I never saw the patient again.

Q. No, because you have somebody, or you did have somebody in Mr Davies' practice who was specifically for dispensing.

A. Yes.

Q. Whereas obviously optometrists do the –

A. You can do it, you can do it yourself.

Q. You can do it, but they often have dispensing assistance.

A. Yes.

Q. So you can't say exactly what happened with that patient?

A. No. It looks as if she did have two pairs, but I don't know. That is what the ring down the bottom is, but that is the instruction I left on the basis that I came to that conclusion, enhanced the conclusion, or the suggestion, rather, of Ms Macken.

Q. Can I ask you to look at the patient's statement, page 5 and page 6? I just want to ask you about what the patient has recorded - though only very briefly - paragraphs 26 and 27. She says

“Once again the pain and blurred vision had gone by the time I saw Mr Phillips. I repeated my symptoms to him and pointed to the spot where I suffered from pain in the evening.”

Do you recall that?

A. I can't remember her saying that she would have pointed to frontal headaches.

Q.

“I do not remember Mr Phillips asking me any questions throughout the examination and he categorically did not give me any anaesthetic”.

Well, we can see that you obviously did,

“either by injection or drops. I would remember something like that. None of the opticians I saw at the practice measured the pressure of my eyes at any point.”

She says she cannot remember what tests you performed. Then she says you walked out of the room with her glasses muttering to yourself, “what the bloody hell is going on here?” What do you say about that?

A. I didn't do it.

Q. Is that been anything you have ever done?

A. No, if I had any comment to make about the spectacles that she brought in, I would have done it initially before I started any examination. If I needed to analyse them there was a focimeter in the consulting room. A focimeter is a

machine which you use in order to analyse the prescription of whatever spectacles. It tells you what the powers of the lenses are.

Q. I think she then says –

A. I had no reason, sorry. I had no reason to leave the room. I didn't have the benefit of perhaps Ms Macken being there, I didn't have a professional colleague, so I had nobody to go and consult. I had no reason to leave the room.

Q. She then says,

“he did explain to me that the lower part of my varifocal lenses were too strong and that he would prescribe a lower strength”.

Well, we know that's completely the opposite.

A. Yes, that is not right. So her powers of recall are somewhat –

Q.

“no other advice at the end of the examination or tell me when to return if the pain continued.’

Is that right?

A. No, I didn't say that. I would have said, as I have been doing for forty years, “if you have any problems, come back and see me”. I was there sufficiently often, two days a week, four half days a week, or whatever combination. I was there sufficiently often for her to return to me and for her to see me. That is what I have been doing for whatever length of time and I had no reason to alter my habits.

Q. Can I just ask you, please, now to look at your letter, page 52, I think? It may help if you keep your finger in page 22 at the same time. This was a letter dated 4 March 2006 and was addressed to the Optical Council in response to the complaint. As we have already heard from Mr Alder, all the hospital records and other matters went to the Optical Council and would have been given to you as well.

A. Yes.

Q. You have set out in the first paragraph, the first proper paragraph, that the patient experienced three episodes of pain after reading and some headaches. Also informed that she is not happy with her current prescription and preferred her old prescription.

“I reviewed the patient notes where she had been seen previously on 12th and 21st. Their notes detailed early lens changes, minor corneal changes, Fuchs' dystrophy and C/D ratios of 0.2 with the discs appearing shallow in both eyes. The records show the discs and macula to be healthy. I concluded that these notes were accurate and still relevant”.

What did you mean by that?

A. Yes. Well, I checked it all. I looked at the back of the eye with the ophthalmoscope and I used the slit-lamp. Sad to say there was nothing triggered. I did not look at the angle.

Q. Did you think that you needed to look at the angle?

A. No.

Q. Was there nothing that would have caused you to?

A. No. I took the intra-ocular pressures as they are recorded at 13, which is, and I think Dr Harper mentioned, it is on the low side anyway. There is a bracket, a range, a whole range, and if anything it tends to be on the low side of that range. So nothing triggered me to go back and think, 'Gosh I had better look at the angle', or I didn't.

Q. Over the page, you say,

"The patient was finding it difficult to cope with her varifocal lenses because of the index myopia".

You therefore advised the patient to have separate near and distance spectacles, subsequently dispensed.

A. Yes.

Q. Then you say,

"A full and thorough examination which addressed the presenting symptoms. Pressures within normal range, C/D assessment reviewed - no abnormalities. In your clinical opinion, the results of your examination, taken with the results of her recent examination, did not warrant a referral".

A. Yes.

Q. You expressed sympathy with the patient, the nature of an acute glaucoma, as compared with chronic, rapid onset of symptoms, having reviewed her medical records,

"I note that on her visit to the Heath Hospital in Cardiff on 6 November 2005 she reports an onset of symptoms of only 1 week".

A. Yes, sorry I misunderstood the hieroglyphics.

Q. Which hieroglyphics; is that going back to page 22? Have you got the right page number? Page 22 the middle number. My page 22 is the hospital record.

A. The hospital record said 1/7. I interpreted that to be one week instead of one day.

Q. Right, so that was the mistake.

A. Yes.

- Q.** What about the point about previous episodes times three within three weeks? I think that would take the patient back to mid-October, anyway.
- A.** It would, and that would, three weeks, post dates the time that I saw her. So if that is what she reported to the ophthalmologist, then it would – she didn't report it to me, which she didn't.
- Q.** There is no question of any red eye. The patient doesn't complain of any symptom of red eye being present when she saw you. Do you agree with that?
- A.** No, there wasn't.
- Q.** Did you know that the Committee had access to the notes? That the Committee were going to have the notes as well, the hospital notes?
- A.** I assumed they had. I can't honestly say that it was put in black and white and plain language that they had, but I made the assumption because they came to me. So if they came to me then –
- Q.** Can I just ask you, then, about slit-lamp examination? You told us that you did do one.
- A.** Yes.
- Q.** Intra-ocular pressures, you told us that you did that. My copy says, 'undertake', but I assume that means 'undertake', "ocular investigations to try and identify the cause of the symptoms". Did you do that?
- A.** I did, yes.

Mr Swinstead: I think you are on the wrong page.

- Mr Stern:** I beg your pardon. Thank you very much. Well, slit-lamp examination, it is the same thing you told us. "Adequately identify an explanation for the presenting symptoms", you told us about that. "Examination of near visual acuity".
- A.** I did it because that is what I give the patient. A box - it is about 6" or 7", no maybe 8" square, it is internally illuminated, and that is the method that Mr Davies had. That is the equipment that Mr Davies had, in order to get the patient to read. Can you read? It is a square box of, I don't know, about 7".
- Q.** I don't need to ask you about the adequacy of the records because obviously it depends on –
- A.** I didn't put 'N6' or 'N5', I am sorry, I didn't.
- Q.** Don't worry. All right, thank you very much, Mr Phillips.

MR PHILLIPS cross-examination by Mr ALDER

- Q.** Mr Phillips, if I could ask you a couple of questions if I may? You refer at the end to performing an examination of near visual acuity and of performing a slit-lamp examination, but your evidence at the very beginning was that you have no independent recollection of this examination. Is that right?

- A.** No, the question was, 'do I recollect the patient'. I don't. It is nearly two years ago. I am relying on what I have written down. I don't have to recall memory.
- Q.** So if we rely on what you have written down, we can conclude that there was no examination of near visual acuity, because there is no record there.
- A.** I didn't write it down. I told you, I didn't write. I gave the patient the standard piece of equipment that Mr Davies has in his practice, allowing the patient to read. It is much preferable to have a standard piece of equipment internally illuminated, or otherwise, rather than giving them the daily paper.
- Q.** But you can't specifically recall performing that examination for this patient on the 10th?
- A.** Yes I did, but I didn't recall the level at which she saw.
- Q.** You also now specifically recall performing a slit-lamp examination?
- A.** No I don't remember. I have written it down. I have written, 'Lens opacities both eyes', and I have written 'Fuchs' both eyes'.
- Q.** Well, perhaps it is my note that is at odds then, Mr Phillips, in that I understood your evidence to be that you were able to confirm the lens opacities by dint of your use of ophthalmoscopy? That was the use of the slit-lamp examination?
- A.** I didn't. What I said was that I looked at the back of the eye with an ophthalmoscope. I didn't get a particularly good view of it, so I then proceeded to find out why I didn't get it. I then confirmed, as has been previously written by Mr Davies, that this Patient A had lens opacities. Whilst I was at the slit-lamp I took the opportunity to have a look to confirm if I was comfortable that she also had Fuchs' dystrophy, which is a minor corneal changes, at that level. They were not major. That would then give rise to the visual acuity being recorded and not varying at all.
- Q.** The symptoms which Dr Harper has referred to in his opinion as being indicative, or potentially indicative, of the spectrum of symptoms for glaucoma, so headaches, blurring of vision, pain, would you agree that those are symptoms which could be, could be, indicative of early stages of glaucoma?
- A.** They could be indicative of lots of things.
- Q.** Such as?
- A.** Well, I eliminated some of the things. That the visual problems were due to lens opacities or the minor corneal changes.
- Q.** What other ocular issues, conditions or abnormalities could be indicated by symptoms of headaches, pain above an individual eye and blurring of vision?
- A.** Well, in my opinion, patients have for non-tolerance of spectacles, particularly a difficult prescription, namely varifocals, a different way of making up the spectacles; they can come back and complain what they describe as pain. Somebody else might describe it as stress or discomfort.
- Q.** Issues of pain, headaches, blurring of vision, could be indicative of symptoms of glaucoma. Do you agree with that?

- A.** It could be.
- Q.** So when you were examining a patient it would be in their interests to discount that as potential?
- A.** I did, I took the pressures which is the standard procedure for trying to eliminate chronic glaucoma.
- Q.** There was nothing in your mind that stimulated you to look at the angle of this patient?
- A.** No.
- Q.** That would have assisted you in concluding or discounting whether glaucoma was a potential for this patient?
- A.** It may have, keeping in mind it is not a specific measurement. It is an assessment.
- Q.** You chose not to assess that?
- A.** No, I didn't do it. I didn't choose - I just didn't. It is not a choice; I just didn't do it because nothing triggered me to do it.
- Q.** You had a patient, Mr Phillips, you are attending with, as you describe, symptoms which could be part of the spectrum of symptoms for ocular abnormalities including glaucoma, yet there was nothing that triggered in your mind the need to observe the angle of this patient's right eye?
- A.** No. If you look at my record, all the problems revolve around the reading. What does the record say?
- Q.** The record card itself, you have said, some of it is your handwriting; some of it is not your handwriting –
- A.** The relevant bit is my handwriting, yes.
- Q.** It is all relevant, Mr Phillips. I wonder if you could assist me. The section in the bottom right hand corner, refers I think to the dispense if that is right. It is at page 11 in the bundle. The notations in the top left hand corner are yours.
- A.** Yes.
- Q.** The clinical data in the centre right is yours.
- A.** Yes.
- Q.** Everything on the left hand side is yours.
- A.** No.
- Q.** Which bit isn't yours, Mr Phillips?
- A.** The words 're-check' 'Hugh Phillips not full eye examination'. That is put there by the person –
- Q.** Subsequently - subsequent to your examination.
- A.** That was put there whenever. I am not sure, but not by me. It was put there to aid the clerical staff not to charge this patient for what work I had done, I assume. I didn't write it.

- Q.** Okay. I have no issue with that. The issue, though, we turn to is in respect of the dispense and so everything, you see where it says there 'First pair' and you have a line across that, is everything beneath that –
- A.** I didn't write that.
- Q.** That's the dispensing section?
- A.** Yes. Not me.
- Q.** Very well. So what actually did you prescribe to this patient on 10 October?
- A.** Two pairs. Whether they were dispensed or not I can't vouch for it; even to this day.
- Q.** Well, your evidence was that you have no independent recollection of this examination; you are dependent on the record card for your recollection now.
- A.** Yes.
- Q.** There is nothing in your handwriting which shows what you dispensed or prescribed during that examination, is there?
- A.** I didn't dispense anything. I left instructions to make two separate pairs of lenses.
- Q.** Why does it say, then, in the first section 'First pair', circled 'vari' as in varifocal, I assume?
- A.** I have no idea. I didn't do it.
- Q.** Why would it note 'S/Seisor varifocals', if you had prescribed two pairs?
- A.** I don't know. I didn't write it. That is not my handwriting. I can't vouch for it. I am not sure if they were made up or not. I didn't. I didn't dispense them.
- Q.** I appreciate that you are saying you had not written this, and there is no point taking it – but it says 'return lenses as non-tol'. Are you able to tell the Committee when that would have been noted?
- A.** No. I can't. I didn't write it so I haven't a clue. I am sorry, but I can't help the Committee on that point.
- Q.** So it could in fact be that you prescribed and dispensed for this patient varifocals as per circled there for this patient, who then subsequently returned on 24 October and an additional two separate lenses were then dispensed to her?
- A.** I have no idea. I didn't do the dispensing, so I cannot vouch for it.
- Q.** You have said, I think in your evidence - again, if my notes are incorrect please tell me - that you had not recorded the C/D ratio because it had already been recorded by Mr Davies on 12 September.
- A.** Yes.
- Q.** Is that your normal practice, not to record clinical information that you have if it is recorded by a previous optometrist?

- A.** That is normal practice, if it is a new patient. Keeping in mind this is a third examination, or a third time that this patient had been seen, I made reliance upon certain information that was already at my fingertips. But that is not my normal practice. I might be referred to a cold patient, and I would put the C/D ratio or anything else I had come across.
- Q.** How is a subsequent optometrist or locum optometrist to be aware of the conclusions you have made as a result of your clinical examinations if you don't record them, Mr Phillips?
- A.** If the subsequent optometrist that saw this Patient A, he or she would have at their fingertips three very closely timed examinations.
- Q.** The record prepared by Mr Davies on 12 September 2005 shows, "Distance vision poor, varifocals for three years, eight years ago suspect retinal –" I think that was agreed that was referring to a previous retinal detachment suffered by the patient.
- A.** Retinal tear, right eye.
- Q.** Retinal tear, right eye – oh, I see, thank you. She is prescribed varifocals by Mr Davies, she returns nine days or so later, sees your colleague, Ms Macken, who records distance vision reducing, she is struggling wearing the spectacles over a period of time. She is noting headaches.
- A.** I don't agree with you about Ms Macken recording the distance vision decreasing, because that is not true. If you look at Mr Davies' record, the distance vision for the right eye is 6/9, the left eye is 6-. If you look at Ms Macken's, the distance visual acuity for the right eye is 6/9 and that for the left eye is 6/6-.
- Q.** So in the Symptoms and History section, what they may actually confirm is what the patient was presenting with, saying –
- A.** I don't understand. I am sorry, would you repeat that question?
- Q.** If I could ask you to turn to page 12, which is the record by Ms Macken? In the 'Symptoms and History' section, it is recorded there 'D/V' and then there is an arrow pointing down. Would you agree with me that that would indicate that the patient has presented with, in her mind, a symptom that her distance vision is reducing?
- A.** It is a question you need to put to Ms Macken. It is not my shorthand.
- Q.** Okay. As the subsequent optometrist reviewing these records, what would you have made of that?
- A.** I might well have interpreted that distance vision had dropped as per the patient's –
- Q.** As per the previous question.
- A.** - but subsequently that is not found to be the case, is it?
- Q.** So we have a notation also made by Ms Macken of the Symptoms and History. She records, 'HA's plus pain RE 5 minutes'. What would you interpret that to be as the subsequent optometrist?

- A.** That she had had headaches and that for five minutes she had had pain in the right eye, and it had gone.
- Q.** You then are presented with the same patient who attends to you on 10 October 2005 recalling more episodes of frontal headaches and more episodes of pain.
- A.** After near.
- Q.** The point being, this patient is suffering from pain that is not going away despite her perseverance with varifocal lenses.
- A.** No, it says that after reading, or whilst reading, she is having, she had, three episodes of pain. Whilst reading. That is what the record indicates, and that subsequent to that she took the understandable step to revert, because it was reading, to revert to her original prescription that she had before Mr Davies saw her, and she reported that she preferred it.
- Q.** I wonder if you could just assist me with your record on page 11? Dr Harper referred to a reference to your notation of Fuchs' dystrophy.
- A.** Yes, but he didn't have a good copy of my record card, so he didn't actually – he assumed that I hadn't done anything with a slit-lamp, but unfortunately he didn't have a good copy.
- Q.** You will need to assist me, then, because I have the same copy. You have noted 'FD', or 'Fuchs' dystrophy', or how have you noted it on your record card that is available to you?
- A.** The original says, 'Fuchs' both eyes' and the Fu is missing because it was poorly reproduced, but the last 'chs BE' is produced, copied.
- Q.** How does that appear to you when you examine a patient? How does actually that condition manifest itself so that you can make that diagnosis?
- A.** You look at the back; you look at the endothelium, the back surface of the eye with the slit-lamp.
- Q.** How does it appear to you as the optometrist?
- A.** Well, there are minor changes to the back surface of the cornea.
- Q.** Is that something that is quite prevalent amongst patients?
- A.** No. I don't know what the percentage is, I am sorry.
- Q.** The notation made by Mr Davies is of Fuchs' dystrophy in his note as that being a previous history for this patient. I am going to suggest to you that you didn't note that on your record - that that is actually something you were transposing from Mr Davies' record. Would that be right?
- A.** No.
- Q.** So you independently identified this patient as suffering from Fuchs' dystrophy?
- A.** Yes, the same as Mr Davies did.
- Q.** That wouldn't represent a corneal change, though, would it?

- A. Pardon?
- Q. That wouldn't represent a change in the condition of the cornea? You were just established that which Mr Davies established some month earlier.
- A. Mr Davies is establishing the report that the patient had made that she had been told that she had Fuchs' dystrophy.
- Q. Mr Phillips, I am going to put it to you. I am quite clear that you are going to disagree with me, but for the purposes of putting the Council's case, I am going to suggest that you didn't perform a slit-lamp examination. I understand that your evidence is that you have.
- A. Yes.
- Q. I am going to suggest that you didn't perform an examination of near visual acuity. Your evidence is that you did, I think.
- A. Yes, I did, because that was the mechanism for allowing the patient to read.
- Q. Given your absence of the recording of near visual acuity and your apparent absence of your recording the detail of the slit-lamp examination and the general context of your record card, do you accept that your record-keeping itself is inadequate?
- A. No.
- Q. You accept that this is an adequate manner in which to –
- A. Under the circumstances, yes.
- Q. Thank you. Given that your acceptance that the symptoms for this patient with which she presented to you, and your evidence that you accept as Dr Harper has put, that these would, or could be, symptoms of ocular abnormalities, including glaucoma, do you accept that in fact your conclusion that this patient was suffering from a non-tolerance situation was in fact inadequate? Very long question, I appreciate.
- A. If I understand the question correctly, and I hope Mr Stern will step in if I –
- Q. I am sure Mr Stern will.
- A. In hindsight, at the time, my examination led me to believe that what I did was correct. In hindsight, absolutely. In hindsight she had, and subsequent to me keeping in mind, subsequent to me seeing her, again in hindsight, she subsequently had glaucoma.
- Q. Using, if only then, that hindsight, would you have done or performed different examinations that you did?

Mr Stern: I am not quite sure what that question really goes to.

Mr Swinstead: With respect, Mr Alder, I don't think the one thing you can put is hindsight, because of course we all have hindsight and we all know what the patient suffered from. With respect, all Mr Phillips can actually go on is what he knew or thought at the time and what he should have done at the time. So with respect I don't think you can ask the question.

Mr Alder: Sir, I appreciate that. My reason for asking the question was really one that goes potentially to the allegation itself, of impairment and fitness to practise. It seems to me in the answer being given by Mr Phillips that there may be some degree of perhaps insight or hindsight he was imposing on his practice now. He was saying, 'yes, at the time I did these things and they were adequate', but there may well be a suggestion that he could have now, on reflection, be reconsidering his practice. That was the purpose of my question.

A. Protect me, Mr Stern, please.

Q. No there is no need; we are going to stop the question. That was the purpose behind it.

Mr Swinstead: It is probably my fault, Mr Alder, but I feel I don't quite understand the point. Forgive me.

Mr Alder: Mr Phillips, your representation to the Council of 4 March 2006 recorded and stated that the onset of this patient's symptoms had happened within a week. That was due to the date when she first presented to the hospital on 6 November 2005. Do you accept that in fact the onset of her symptoms, as are recorded in the hospital records, predated that one week which you have referred to?

A. No, I misunderstood 1/7, as did your expert witness, to be one week. If you look at three weeks, which is what the hospital record says, that post-dates my examination of her.

Q. The onset of her symptoms when she presented to the hospital on 6 November –

A. Started after I saw her.

Q. But certainly over one week before she had attended at the hospital. Mr Phillips, if I could take you to the hospital records if I can. They are at page 23 of the bundle, the very top of page 23, you see the notation I think it is "6 November 2005, red eye, onset 1/7 ago, previous episodes in past x 3 within 3/52", so within the last three weeks of that presentation.

A. She had a red eye one day ago, as we now discovered, as your expert witness misinterpreted the 1/7 just as I did.

Q. Did you also misinterpret the 3/52 then Mr Phillips?

A. Well the 3/52, she is having episodes. The 3/52 if you go back in days, the 3/52 refers post to my seeing her. I think if you add three weeks on to, or take three weeks from 6 November, it actually finishes after I saw her on 10 October. So she complained to the hospital of something that actually wasn't there when I saw her.

Q. In your response, though, to the Council, if I could take you to that. The point may be a moot one; page 53 of the bundle.

“Having reviewed the patient’s medical records I note that on her visit to the Heath Hospital in Cardiff on 6 November 2005 she reports an onset of symptoms of only 1 week”.

Given the notation of 3/52, do you accept that that response is inaccurate?

A. She had a red eye for a day. Not a week. She had symptoms, yes, all right, okay, I misinterpreted at the time somebody else’s hieroglyphics and as has already been said by your expert witness, people have different use of hieroglyphics in order to describe what may well be similar problems.

Q. Finally, Mr Phillips, if I could take you to page 13, please? Again, it is the final allegation that faces you. You refer to the patient’s previous records indicating minor corneal changes. The record by Mr Davies shows the Fuchs’ dystrophy to have been recorded in the Symptoms and History section.

A. Yes.

Q. I am right in thinking, am I, that actually therefore that is not a conclusion which Mr Davies himself has come to as a result of his examination of this patient?

A. No, but he used a slit-lamp and presume that he came to the same conclusion. I used the slit-lamp and I did come to the same conclusion.

Q. Where on this note, where on this record card, is there any indication of a minor corneal change?

A. Which card are you talking about?

Q. The one we are talking about - page 13 of your bundle.

A. That’s Mr Davies.

Q. Mr Davies?

A. That’s not mine.

Q. Your response to the Council stated quite clearly that the notes you had referred to showed, indicated, minor corneal changes.

A. Because I looked at the cornea with a slit-lamp.

Q. Your response is based upon the records that were kept by a previous optometrist - in this case, Mr Davies.

A. My response was about all the records that refer to this patient.

Q. Your view of Mr Davies’ record - am I right in thinking - that records minor corneal changes?

A. He doesn’t.

Q. Exactly, Mr Phillips, he doesn’t. I am grateful, thank you. Thank you, Madam.

A. But I do.

Ms Hallendorff: Mr Stern?

Mr Stern: I just want to be clear about one thing before Mr Phillips goes, bearing in mind that he may not be here tomorrow. There was a suggestion that Mr Phillips had not used a slit-lamp. That was a suggestion put by Mr Alder, and I am just slightly concerned if that is an issue which you have to determine, which it is, where the evidence comes from to suggest that to Mr Phillips, because I don't want to miss it and I want to be able to deal with it in due course.

Mr Alder: The evidence, Madam, was that of Dr Harper whose view of the records - prepared by Mr Phillips - indicate no particular records which could be indicative of a slit-lamp examination.

Ms Hallendorff: If I have understood correctly, Mr Swinstead will tell me if I am wrong, Dr Harper was not able to read the left hand side of this report which cut off the bit that says 'Fuchs' both eyes'. However, above it, it says 'lens opacities both eyes' which Dr Harper admitted, and that can be done by a slit-lamp as I understand it.

Mr Alder: Madam, the lens opacities could be equally attributed to an examination using an ophthalmoscope, which is why, Madam, I put the question to Mr Phillips in the manner which I did. It is entirely a matter for you whether you accept the evidence of Mr Phillips and his record card. I have explained to you the basis on which the Council have put its case in respect of that particular allegation.

Mr Stern: Putting a question is one thing. Of course he is entitled to ask a question, but that wasn't a question, that was a suggestion, and that is really the reason why I am on my feet asking for what the evidence is in relation to it. Because I don't want Mr Phillips to go tomorrow and for there to be some final address to you on this point and then we have a dispute about it and then Mr Phillips has to be recalled. I really don't want there to be any difficulty about that.

Mr Swinstead: I think, Mr Alder, the point is a simple one. Is it the Council's case, does it remain the Council's case that Mr Phillips did not perform a slit-lamp examination? That effectively is the question.

Mr Alder: Madam, I apologise. It is important for me to clearly take instructions on this point at this stage.

Mr Swinstead: I think it is two points. It obviously relates to Dr Harper's evidence and what he could or couldn't read on the card, but I think, particularly if Mr Phillips isn't going to be here, I think Mr Stern is entitled to know when you make your final submissions tomorrow, will you be arguing that point, and if you are, in the light of the exchanges in cross-examination, indeed your examination of Dr Harper, what evidence you would be relying on to assert or to continue to assert that Mr Phillips did not perform a slit-lamp examination?

Mr Alder: Sir, there is clearly a point of the evidence that has arisen over the last hour or so and it is important for me to take instructions on the point, because it is clearly the Council's case and how it presents it. I need to be clear.

Mr Swinstead: Are you asking for a few minutes?

Mr Alder: It would be helpful for possibly five minutes or so.

Ms Hallendorff: Okay.

Mr Stern: Obviously Mr Phillips is still giving evidence, so it is probably best just in case any matters arise, that we don't actually discuss any matters, so I hope he appreciates it is not being rude.

Mr Swinstead: Mr Phillips you are still under oath, so please don't talk about the case to anybody in this adjournment.

A. No. I will go somewhere else.

Mr Swinstead: As with Dr Harper, Mr Phillips, you can talk about anything else, but you can't talk about the case.

[The Hearing adjourned at 15.44 pm]

[The Hearing resumed at 16.02 pm]

Ms Hallendorff: Mr Alder.

Mr Alder: Thank you Madam. Thank you for the opportunity to seek instructions. My instructions are that the Council proceed with this allegation on the basis that, as I put to Mr Phillips in cross-examination, that the notation of Fuchs' dystrophy, which is not noted on my card, which I think is a photocopying issue as opposed to anything else, and Mr Stern has agreed to provide me with a copy of his version, was something which could have been transcribed by Mr Phillips from the previous record card of Mr Davies, and that the phrase 'LOBE' is a notation which could have been made as a result of ophthalmoscopy.

The Council's suggestion - and the case is put on the basis that there was no performance of a slit-lamp examination, given the absence of specific records, and in the absence of any notation of the anterior chamber angle which is significant in a case such as this with a patient presenting with these symptoms. Those are my instructions in respect of that particular allegation.

Mr Swinstead: Mr Stern, the Council persists with the allegation. That was the question you asked, and Mr Alder has given you the basis. Now you may no doubt have many arguments against that, but the issue is whether Mr Phillips needs to be asked, or whether he needs to answer any further questions with regard to that today. I hope Mr Alder has made the Council's position clear so that the allegation is maintained on the basis that –

Mr Stern: On the basis that it could have been made. That is what he said. It could have been made from Mr Davies' –

Mr Swinstead: Mr Stern, the argument, it is not now a moment, it is simply Mr Phillips is in the witness box, he will not be here tomorrow, so the point is whether there are any points that either side would need to take or would wish to question Mr Phillips on that matter or indeed anything else.

Mr Stern: Of course it does raise a considerable number of character issues, obviously as well, obviously as a result of that suggestion, because it is suggested that the gentleman is not telling the truth about it, so that is obviously an issue of relevance.

Mr Swinstead: Well, that is a matter that will have to be –

Mr Stern: Yes, well, that is why I wanted to know what the position was, because it obviously is relevant. Sorry, Madam, I don't know if you had any other questions?

Ms Hallendorff: No. Has Mr Alder finished?

Mr Alder: No, I had finished, I thought the Committee were asking.

Ms Hallendorff: Mr Stern, is there something you want to add before we –

Mr Stern: No, no I just want to ask a few questions.

Mr Swinstead: He is re-examining.

Mr Stern: I think we have a slightly better copy here, and I will first of all get the witness to identify it if I may. Do you see the copy 10 October? When I say slightly better, it is more of the left hand side.

A. Yes, it does.

Q. Perhaps, first of all, if the Committee could see that before I ask you more questions about it.

[Mr Stern's copy is shown to the witness and to the Committee]

Mr Swinstead: Mr Stern, something does occur to me, I know something is being looked at so forgive me, and I think perhaps we ought to resolve it on the basis of what you have just indicated, when Mr Alder has had a chance to –

Mr Alder, is it your specific suggestion therefore that Mr Phillips has simply put in those two references, the matter we have just been looking at, the 'LOBE' and the 'Fuchs' BE', but that he has, as it were, not carried out those tests? Is that your allegation, and that he has simply transcribed what Mr Davies had recorded? Is that your case?

Mr Alder: Sir that is my instruction. That is the Council's case.

Mr Swinstead: With respect, Mr Stern, I think Mr Alder should put that forward.

Mr Stern: He did.

Mr Swinstead: I am sorry, I wasn't sure that he had actually put that.

Mr Stern: That is exactly what got me to my feet in the first place.

Mr Swinstead: I am sorry, forgive me, I may have misunderstood his question. I don't know if it was absolutely clear to the Committee, but I hope we want to make this absolutely clear for certain, very good reasons. Mr Alder, before Mr Stern re-examines, just so the Committee understand absolutely clearly what you are putting, could you put to Mr Phillips exactly what your case is on this point. Sorry, Mr Stern, but it is important.

Mr Alder: Sir, I can do it again –

Mr Swinstead: Because he may have not understood. I certainly didn't get the absolute point of it and, because it is important for certain reasons that may come up in the future, I want to be absolutely clear in the future of the case. I want you to put it clear so the Committee understand absolutely how you put the case.

Mr Alder: Mr Phillips, you have answered this question already. I would be grateful for your indulgence. I put to you that you had not in fact performed a slit-lamp examination.

A. I did.

Q. I put it to you that your reference, I have seen it now, of Fuchs' dystrophy was something that you had transcribed from the earlier record of Mr Davies.

A. He didn't make any reference in his examination. You have made that point clear.

Q. In your reference, LOBE lens opacities being present for this patient were an examination result which came to you as a result of ophthalmoscopy as opposed to slit-lamp examination.

A. No.

Q. And you made no note or reference to the angle of the anterior chamber for this patient.

A. No, I didn't. Nothing triggered me to do it, but I didn't.

Q. Thank you, Mr Phillips. Thank you, Sir.

Ms Hallendorff: Mr Stern.

Mr Stern: Can we just look, please, at the 10 October entries? On the left hand side we can see 'LOBE'. What does that stand for?

A. Lens opacities both eyes.

Q. For some reason, it is suggested that you did that with an ophthalmoscope. Did you do that with an ophthalmoscope?

- A.** No.
- Q.** Underneath we can see 'Fuchs' BE'. What does that stand for?
- A.** Yes. Fuchs' dystrophy both eyes.
- Q.** How did that come about?
- A.** By me using the slit-lamp.
- Q.** Are you lying to the Panel about that?
- A.** No.
- Q.** And what do you say of the suggestion that you are?
- A.** I take great exception to it. In fact, it might be interpreted that I was committing forgery.
- Q.** Perjury, I think, rather than forgery.
- A.** I am sorry, Mr Stern, perjury.
- Q.** Do you normally put the findings in the lower half and the history in the top half of the notes as we can see there?
- A.** Because that is how this record card is set out, yes.
- Q.** Could you tell us, I don't want to embarrass you, but obviously this is an issue that is now important? Could you tell us something about what you do, if you want to? About some of the other functions and roles that you perform in society, if you want to tell us, I don't want to embarrass you, but if you want to tell us? I leave that choice with you. Do you want a minute to think about it?
- A.** This is a public meeting and could be on record.
- Q.** Well, it will be on record, but I don't see hoards of press here, or any press here, but obviously it is recorded. There is a transcript, and the transcript goes on the website. Do you want a little time to think about it or not?
- A.** One half of me says, 'yes, I should', and one half of me says, 'no'.
- Q.** That is the story of all our lives.
- A.** Hindsight would be wonderful. It is judged by other people whether I tell the truth because of my public positions and it is not my – all right, I am a Justice of the Peace.
- Q.** How long have you done that for?
- A.** 25 years. General Commissioner of Taxes.
- Q.** How long have you done that for?
- A.** 20 years.
- Q.** You told us about all the committees you were on in Wales. Is there anything that you want to expand in relation to that?
- A.** I was trusted by my professional colleagues in order to represent them truthfully when going to committees, Family Practitioner Committees, or whatever.

Q. Is there anything else that you want to say about that area?

A. No, I don't think so. That is enough.

Q. I don't know if you have any questions, Madam?

Ms Hallendorff: Mr Baldwin do you have any questions?

Mr Baldwin: No.

Ms Hallendorff: Mr Reily?

Mr Reily: No.

Ms Hallendorff: Mrs Huka?

Mrs Huka: Yes, if I may. Mr Phillips, because I have got page 11 of the notes open, I understand this question of, I think it is 'LOBE' was put to you, and you said, and the question of it being an ophthalmoscope or not. I know that in the beginning of the questions you said that you would have to rely on your notes because for obvious reasons your recall of the situation was poor given the passage of time. How do you remember whether it was an ophthalmoscope or not? What is so particular about that that makes you remember that piece of information?

A. Because it would go hand in hand with Fuchs' because I don't know, somebody more erudite than myself might be able to tell me how I could come to the conclusion that it was Fuchs' dystrophy in any other way than using a slit-lamp, and at the same time to ascertain the reasons why I was not getting a crystal clear vision because the back of the eye, I used the slit-lamp to come to a conclusion.

Q. On the issue of the notes, because of the proximity between the time your colleague saw this particular patient and you did, you tell us in your evidence that you relied on their notes.

A. I used their notes, yes.

Q. Okay, except of course when it was a new symptom. If it was a new symptom you would have written it down, is that right?

A. I am sorry, Madam, would you –

Q. So you used your colleagues' notes to actually look to see if it was any different from what you have observed when you were seeing the patient. Is that true, or not?

A. True, yes, I would look at the notes frequently.

Q. Yes, and if there had been any new symptoms, what would you have done then?

A. Written it down.

Q. Okay, now, in the case of the headache, was that a new symptom or not?

A. No, it had been noted.

Q. It had been noted?

A. No, it had been noted by Ms Macken.

Q. Ah, so that is where you got that. So the headache for you, then, was just Ms Macken's note rather than you picking it up?

A. No I wrote down that the patient had complained of frontal headaches to me.

Q. Ah, okay. So could you just enlighten me a little bit on what the obvious symptoms of glaucoma are - the obvious symptoms of glaucoma?

A. Well, if it is the closed-angle, the eye would be red, there would be extreme pain and there may be sickness, but the patient didn't have red eye, nor was sick, nor was in extreme pain when I saw her which subsequently according to the hospital notes, she did. Not the sickness, at least I don't think it said sickness, but it said she had a red eye and pain and that would have been presented if at the time we saw her she had acute glaucoma.

Q. She didn't actually complain of pain to you, then?

A. She complained of three episodes of pain after reading. It isn't a case of at night time as was the case when she went to the hospital. It was some early hours of the morning, I think, I believe at 5 am. At night time when the pupil gets larger the iris blocks the angle and those are the most frequent, those can be the most frequent occurrences to cause an acute attack of glaucoma.

Q. In that case, what are the symptoms, then, of spectacle intolerance? Forgive my inadequate language, I am not an optician, but I am trying to establish how you would distinguish?

A. They can be many and varied. As I said in my evidence, I have found patients who have come in complaining of pain and with difficulty in seeing. I would have done an initial examination or a re-check and found that on making new spectacles all the problems disappear. I don't know how often it happens, but it does happen, and with all the problems that Patient A had, as I recorded, they have revolved around reading problems.

Q. Did you at any time consider that the pain could be anything other than an intolerance to the spectacles?

A. No, everything pointed to the fact that there was intolerance.

Q. Thank you.

Ms Hallendorff: Thank you very much. Mr Swinstead, do you have anything you wish to ask?

Mr Swinstead: Madam, no, I have no questions.

Mr Stern: May I just for the assistance of the Panel draw your attention to Dr Harper's report, page 56 - page 9 of the internal pagination of the report. If we look at the sub-paragraph, "Were the symptoms which Patient A reported to Ms Macken indicative of acute glaucoma?", you can see the hallmark

symptoms that are set out there. I hope that answers the question that you asked.

Ms Hallendorff: It is page 56 of Mr Phillips' document.

Mrs Huka: Thank you.

Mr Stern: Those are all the questions I have, thank you very much.

Ms Hallendorff: Thank you, Mr Stern. Mr Alder?

Mr Alder: No, thank you.

Ms Hallendorff: Thank you, Mr Phillips.

[Mr Phillips stands down]

Mr Stern: Bearing in mind the time now, it is 4.20 pm. We are obviously not going to finish Ms Macken.

Ms Hallendorff: I would suggest we break now and reconvene at 10 am tomorrow morning.

Mr Stern: I wonder if I might ask your indulgence just in relation to one matter, because Mr Phillips is here. They are separate cases and therefore to some extent one can deal with certain matters separately. Obviously we have not heard from Dr Eperjesi in relation to his view, and I don't ask you to take that into account at this stage, but in my submission when one looks at Allegation 1(i), that is to say whether Mr Phillips did not perform a slit-lamp examination, there is no evidence upon which the Committee could conclude that Mr Phillips did not perform a slit-lamp examination and the suggestion based we are told on instructions, rather than evidence, because the evidence that has been pointed out to you is that it could have been made as a result of seeing Mr Davies. That is no evidence at all, and certainly not evidence on which a properly directed tribunal could be satisfied so that it was sure that no slit-lamp examination was carried out. It is a short discrete point and I thought that that may be able to be dealt with, as it were, in the time, still giving, I hope, time to finish before 5 pm.

Ms Hallendorff: Absolutely.

Mr Stern: But I thought that might make use of the time that we have left. So that is a short point. There is no evidence in relation to it and you have not had your attention drawn to any, other than an assertion by Mr Alder that it could have been made as a result of seeing Mr Davies' entry, but that is not evidence.

Mr Swinstead: Mr Stern, I was just going to remind the Committee of the Rules and just thinking about whether in fact such a solution at this stage would fall within the Rules, and I just need to remind myself of the procedure. *[Pause]*

I am really looking to see if the Rules provide a particular time for a submission to be made as to whether or not any part of the allegation is supported by the evidence.

Mr Alder: Sir, as I understand it there is no specific Rule which deals with that as a discrete point.

Mr Swinstead: No, I was just thinking that in some jurisdictions there is an inclusion of the Council's case whereby such a submission could be made. You would like to make your submission on that point now?

Mr Stern: Well, it is a discrete point. There is no other evidence that will affect it, and in my submission there is no evidence in relation to it. As a matter of fairness, if that is the view of the Committee, as I say, we have heard no evidence that is relied upon, then on that basis the matter should not go any further and Mr Phillips should not be in jeopardy in relation to it. As he is not going to be here tomorrow, obviously it would be fair to deal with that today if it can be dealt with today.

Mr Swinstead: Let's see what Mr Alder says.

Mr Alder: Sir, indeed it is a matter entirely for the Committee and whether they consider that submission, if such a submission were to be made, of course it would fall perhaps crudely to the old criminal Galbraith test as to the nature of evidence before this Committee. Mr Phillips' evidence was also that he had no independent recollection –

Mr Swinstead: Can we just deal with whether or not the application can be made now? It is really any submission you have now on that point.

Mr Alder: Indeed, Sir, there is no rule which provides for the Committee to consider such a submission at this stage, and Rule 50 of the 2005 Rules on page 101, provides that the Fitness to Practise Committee determine their findings as to facts as to whether or not the allegation is proven and may in fact conclude that the allegation of deficient professional performance is one which encompasses such decisions and determinations of fact at that point, at that relevant stage.

Mr Swinstead: Madam, it is really a matter for the Committee, but the reality is that your Rules are silent on whether a submission such as Mr Stern wishes to make at this time can be made, if your Rule, as Mr Alder says, provides for determination as to fact at the conclusion of evidence and submission as to whether an allegation is proven, and I think it is entirely a matter for you.

I could only say this, that I think you have to balance in your own minds the provision of your Rules, if I can put it that way, against any principles of natural justice which would perhaps suggest that at any time in a hearing if there is no evidence on a particular part of the allegation, then such an application could be made at that point.

But it does concern me that no provision is made in the Rules, even for such a submission to be made at the conclusion of the Council's case and therefore whilst there may be some sympathy for Mr Stern's application on the basis that Mr Phillips will not be here tomorrow, it is right to say that the Rules do not provide for such an application.

As I say, I think you have to balance the contents of your Rules against the principles of natural justice which are that at any stage in a proceeding, and drawing an analogy with a criminal case in a court, a submission can be made on account of an indictment at any stage, not merely at the conclusion of the prosecution's case. As such, a submission could be made part way through a defendant's case, but that being the case, and bearing in mind to a certain extent you are governed by your Rules and there is no provision in your Rules, I think those are matters that you have to balance in your own mind.

I don't think I can say anything further than that, unless either party would wish me to say anything further. I think it is a matter for the Committee whether they will hear this application.

Ms Hallendorff: Could you explain, perhaps, to me and I have not had experience of this before, as to why you are making this submission now? I appreciate Mr Phillips will not be here tomorrow for a very good reason, but I cannot see at the moment how that in any way would prejudice a full and fair discussion and a just outcome.

Mr Stern: Well, it doesn't. No, I am not suggesting that, but the question really, as the learned legal adviser has said, is one of natural justice. That is to say that if an allegation is brought against a professional individual or indeed any individual at any stage, then it is only right that if there is no evidence, that allegation should not be pursued in the same way that Mr Alder asked for some time to take instructions on whether or not the Optical Council were going to seek to pursue it. If they had come back and said, 'No, we don't pursue it', presumably that would have been the position at that stage and they would have said, 'please delete that' or some words rather like that, and they would have asked you to do that.

So, in the same way, I am asking you to look at this and to say, 'There is no evidence and it is only right that a professional person should not stand in jeopardy and should know that they don't stand in jeopardy in relation to that particular factual allegation'.

Ms Hallendorff: Thank you. May we have a few moments to discuss this?

Mr Alder: Obviously I have not had an opportunity to respond if that was the submission itself. There are clearly matters – the issue is whether to hear the application, indeed.

Mr Swinstead: That is the issue that the Committee at the moment seized on, should the application be heard. The issue is whether you will admit, that is the point.

[The Committee adjourned at 16.21 pm]

[The Committee reconvened at 16.31 pm]

Ms Hallendorff: Mr Stern has made an application that he be allowed to make a submission that there is no case against Mr Phillips on Allegation 1(i). The Committee has heard Mr Alder's submission in reply and has received the advice of our legal adviser. The Committee notes that the Rules do not provide such a submission to be made at any stage of the proceedings, and once it has considered Mr Phillips' particular situation, and has considered the principles of natural justice, it has decided to refuse this application. Thank you.

I think unless anyone has anything they particularly needed to say, that will conclude the proceedings for today. We will reconvene here at 10:00 am tomorrow morning, and we hope to get a prompt start.

[The Hearing adjourned at 16.32 pm]

Wednesday, 23 May 2007

[Proceedings reconvened at 10.01 am]

Mrs Hallendorff: Good morning. Mr Stern, would you like to continue?

Mr Stern: Madam, I call Sasha Macken.

**SASHA LOUISE MACKEN called and sworn
Examined by Mr STERN**

Q. Can you tell us, please, your full name?

A. Sasha Louise Macken.

Q. Did you attend Cardiff University and study optometry between 1991 and 1994?

A. I did, yes.

Q. What did you do afterwards?

A. I did my year's training in Cardiff Specsavers and then continued to work with them up until 2003.

Q. What did you do in 2003?

A. That is when I left them and became self-employed, so I have been a self-employed locum for the last four years.

Q. Where have you worked - in Cardiff, or a variety of places?

A. Mainly in the Cardiff area, and usually for independent practices. But I still do work for various Specsavers in the area as well; mainly independents.

Q. Approximately how many practices have you worked in in that period of time - lots or just a few?

A. Most of the time I have my regulars, which are my usual days, but I will do holiday cover, so I could say easily 10, 15 different practices.

Q. In your usual days, how many practices does that include, approximately?

A. At the moment, it is two or three different practices I am working for now.

Q. And you have been working there for some time?

A. Yes; two or three years for one of them.

Q. Julian Davies Opticians is one of those practices?

A. When I started locuming, that was one of the first practices I started working for, and I carried that right through until November last year.

- Q.** Is there a Heath Hospital nearby as well?
A. Yes, that is the main hospital in Cardiff. That is the one with the eye department.
- Q.** Do you have any connection with that eye department?
A. That is the main one that I refer to when I am working in the Cardiff area.
- Q.** Is there an eye forum from that hospital?
A. Yes, every six months the consultants will have a sort of – it is presentation-cum-lectures-cum question and answers. So I attend that every six months, and it is CET-accredited lectures.
- Q.** How long have you been going there?
A. I would say since they began, which was about three years ago. I am not entirely sure when they started, but I have attended three or four.
- Q.** Now I want to ask you, please, about 21 September 2005, which is obviously the day you saw Patient A.
A. Yes.
- Q.** Had you seen that patient before?
A. No.
- Q.** Did you see that patient again after that date?
A. No.
- Q.** Do you have the record card? We have the record cards here. Would you like to have a quick look at those?

Mrs Hallendorff: I think it would be helpful.

[The original record card viewed by the Committee]

Mr Stern: Obviously we will give them back after Ms Macken has given evidence and you can spend time looking at them if you wish.

Mr Swinstead: Has Mr Alder seen them?

Mr Stern: I do not think he has.

Mr Swinstead: Mr Alder, have you seen them?

Mr Alder: No.

Mr Swinstead: Mr Alder perhaps should also have the opportunity of seeing them, then.

Mr Stern: Yes. *[Records passed]* Now in relation to 21 September, I believe we have the diary date there and I know that has been given to the Committee. Can I just ask you, is this something you would have seen at the time?

- A.** Yes. As I arrived for the day's work I would have had a look at the diary.
- Q.** We can see crossed out at the bottom is the name of Patient A, "Calling for fitting pm", and we can see you were only working in the afternoon.
- A.** Yes.
- Q.** Can you remember whether that was there when you came to the practice or not?
- A.** It would have been. It was more of a footnote to check with me that I was happy to look at the glasses.
- Q.** Because we can see "Ask Sasha" underneath. What is that?
- A.** That was just to check with me. The receptionists often put notes at the bottom to prompt them to ask me various questions about contacting patients or whatever.
- Q.** On the face of it, you had a full clinic.
- A.** Yes.
- Q.** So do you remember what happened now?
- A.** When Patient A came in, do you mean, or the clinic?
- Q.** No, why it was that you saw her. Did you fit her in between patients?
- A.** Oh, I see what you mean. Yes. During that day there were three patients that did not turn up.
- Q.** Right. So you had time to see her?
- A.** Yes.
- Q.** So that probably explains why it has "Ask Sasha" there. So the patient came in on 21 September 2005. Do you remember now the patient or not?
- A.** I do not really have any recollection of her, unfortunately. It has been a while.
- Q.** Let us see what it is that you have actually recorded. First of all, can you help us, please? The patient has indicated in her statement that she was seen outside, and I am looking at page 4 of her statement. She said, "A lady came out to see me", and she gives your name,
- "who took me to one side and gave me what she describes as a precursory examination".
- A.** Yes, I assume when she said "precursory" she was meaning that I was, as asked, checking the fit of the glasses, checking the position of the varifocals, because when she came in that was her problem. It was not booked in as an eye test. She came in to see someone concerning her varifocals.
- Q.** Hence the word "fitting"? Is that what you understood that to be?
- A.** Yes. More of a sort of fit re-check, I think, as she had already collected them.

- Q.** Do you remember now whether you saw the patient outside the consulting room or whether it was the dispensing assistant?
- A.** The dispensing assistant was not there that afternoon. So that is why the note was for me.
- Q.** That is very helpful. So you saw the patient, yes?
- A.** Yes.
- Q.** And you checked the glasses?
- A.** That is correct. So I would have checked the measurement on the varifocals as well, the strength and checked the fitting and that it had been glazed correctly.
- Q.** Did you take her into the consulting room?
- A.** I would have at some point, yes.
- Q.** Now the notes that we have for 21 September 2005: are the details, symptoms and history there your writing?
- A.** Yes.
- Q.** Is the word "re-check" and then her age and then the history there all your writing?
- A.** The age, the "67", is not my writing, and the box at the bottom saying "Re-check Sasha" was written afterwards.
- Q.** But not by you?
- A.** No.
- Q.** So apart from "age 67" and "Re-check Sasha", the rest was written by you; is that right?
- A.** Yes.
- Q.** Could you help us, then, please, with where it was that you wrote the notes on the left, the symptoms and history?
- A.** When I took them into my room then, I would have had the clipboard and the notes; I would have written those notes as I went along.
- Q.** So that is your practice, is it, to write at the time?
- A.** Yes. As I discussed things with the patients, then I would write the notes down as I go along.
- Q.** Now can you help us, please, as to what it was that the patient complained of?
- A.** Her primary complaint was that her distance vision was blurred or reduced, and that was since she had had the new varifocals four days previously.
- Q.** That is the primary complaint. She said – I think new ones we can see four days.
- A.** Yes, she said she had had the new glasses four days, she had worn them two hours a day and her distance vision was blurred, but also, of course, she had

said with the headaches and the five-minute episode of pain in the right eye. So that would have been what she said to me and I noted it down.

Q. Let me ask you this straightaway. Have you come across patients who have been prescribed new spectacles, varifocals or non-varifocals, who have complained of pain?

A. It is a symptom of getting used to new varifocals and tolerating new glasses. Again, everyone comes with different symptoms, but it is not uncommon to have pain as a description.

Q. When you say "not uncommon", is this something that happens to you once a year, once a week, once a month?

A. I suppose if I had to put a time on it, once a month; once every couple of weeks.

Q. So when Dr Harper says he personally has never come across any patient coming in with pain, is that something that you would agree with or not?

A. I would disagree with that.

Q. In your clinical experience, that has happened?

A. Yes.

Q. Now just tell us if you will, please, what you did, so far as you can remember, with this patient in the consulting room.

A. Having had the initial discussion about her problems, I then would have gone on to check her prescription and her glasses, by using the trial frame and lenses, to ascertain whether Julian's results were the same as mine.

Q. That is Mr Davies, who has carried out the sight test on 12 September?

A. Yes.

Q. Now did you have the notes for Mr Davies' sight test on 12 September?

A. Yes, I would have had those bits of paper.

Q. Right. So you checked the glasses. What else did you do?

A. I checked the reading prescription; I checked the muscle control of the eyes, and the visual levels with the glasses on, with the chart on the wall, reading the letters on the chart. After that I would have discussed my findings with her.

Q. I think Dr Harper agreed that the fitting of varifocals is important, in relation to blurring vision or getting the vision right.

A. Oh, yes. Right at the beginning I did have a look at the fit of the varifocals, marked where the centre of the varifocals were and checked they were fitting her correctly, and again, the whole positioning and angle of the frames.

Q. Were you aware that Mr Davies had changed the prescription on 12 September?

A. Yes, because when I was looking at his record card I did think that was a large refractive change to tolerate. In the right eye particularly there is a 1.5

diopetre change in the prescription, and that would be hard to get used to, I would think, so that was one of my concerns.

Q. So what was your conclusion in relation to the patient?

A. That the symptoms she gave me were connected with the new varifocals and the change in prescription, and that it was a tolerance problem to the varifocals.

Q. Did she ever say that she had "piercing" pain?

A. No.

Q. If she had said that, what would you have done?

A. I would have written it down. I tend to write pretty much what they say. That is what the symptoms and history is, you write down what they say.

Q. On what you had seen and from what you had heard the symptoms were from the patient, did you have any cause to be concerned?

A. Only that she was having a tolerance problem to the varifocals. I was concerned about her varifocals and the prescription change.

Q. In those circumstances, would you carry out any further tests or not?

A. No.

Q. There is obviously a whole range of tests that an optometrist can carry out in relation to any patient.

A. Yes.

Q. How do you decide which test to carry out and which not? Bearing in mind that this is a re-check, not a sight test, because a sight test I think has various criteria that you must follow.

A. Yes.

Q. But on a re-check, how do you decide which tests to carry out and which not to?

A. It mainly depends on her presenting symptoms and problems and from that and the picture I get from her; I decide what tests are suitable for this situation. I would tailor the test accordingly to her presenting symptoms.

Q. So you exercise your clinical judgment at the time?

A. Yes.

Q. Now you were obviously the only person who saw the patient, here anyway.

A. Yes.

Q. And do you just take note of one symptom, or do you look at the patient overall? How does it work?

A. It is the whole picture. You get a feel for the problems the patients are having, because often they can be difficult, so you have to question them and get the whole picture.

- Q.** Is it your experience that patients do have difficulty adapting to varifocals or not?
- A.** It is quite frequent, and usually I do warn them of that, either before the dispense or if I do a collection of varifocals, I will tend to say, "Don't go running around outdoors in these. Take it easy to begin with to get used to the new fitting and the frame". - even a change in frame, without varifocals.
- Q.** The difficulty as I understand it is that with varifocals you have two different types of lenses within –
- A.** There are many different zones that you look through in a varifocal, and again, each manufacturer has different makes of varifocal, so there are quite a few different types of varifocal and they all have a slightly different make-up. They are not all the same. So again, if changing between types of varifocal, I would expect adaptational problems.
- Q.** Was there a particular type of varifocal used at Julian Davies' practice?
- A.** Julian prescribed the particular make, Kodak, the transition ones, and they are quite a rare type of varifocal.
- Q.** You had better just explain that a bit more. When you say transition, what is that?
- A.** The ones that go lighter and darker in the sunlight. That was what she was having, and that particular make is very good for the actual depth of the tint. But it is quite an unusual varifocal.
- Q.** So changing in reaction to the sunlight?
- A.** That is it.
- Q.** Is it your experience that people have particular problems with Kodak or not?
- A.** I only deal with the Kodak ones in Julian Davies Opticians, and it would not be my job to see all those patients for the dispensing purposes. But it is an unusual one. I do not have a lot of knowledge of about those varifocals.
- Q.** That is very helpful. Thank you. Now you have written just below the muscle balance "FD" I think it says "no slit". What does mean?
- A.** The "FD" stands for fixation disparity, so that is a particular test used to check the ocular muscles, and "no slit" means that the muscles were fine and all working together, so to say.
- Q.** You have written I think in the box just below that, "Similar RX". What does that mean?
- A.** That is mainly a reference to what I have said to her after that part of the eye exam, so I would have discussed my findings. So I would have said to her that her prescription is similar, very little change.
- Q.** Then does it say "Give 2/52"?
- A.** Yes, that was again I would have chatted to her about the adaption to the varifocals. I am quite particular about this as well, being very aware as a locum that I do not want to say, "That's fine, off you go". I do like to encourage them, to say, "Any worries, any problems, give it two weeks and do

come back". I do stress that, and I did stress that on the day. Below that it says, "Return if problems", which is part of the same summary.

Q. So you have written "Return if problems. Possible separates" and I think Mr Phillips told us about this, "Give this" –

A. – "prescription if changing".

Q. "Give this prescription if changing". Right. As far as you could tell was the patient content at the end of that consultation with you?

A. I would think so. Yes.

Q. Did she express anything to say that she was not content?

A. Not to me at the time, no.

Q. And approximately – I know it is difficult to remember – how long do you think this took, with the patient?

A. An exam like this would have taken about 20 minutes. I can tell from some of my notes around the actual eye test part that the prescription was quite a difficult one to test. There was some variability with doing the test, just – that was her and her eyes. But I also know that I had a 40-minute break that afternoon from no show of patients.

Q. Right. So you were not in any hurry or anything like that, that afternoon?

A. No.

Q. Now the patient – we do not need to look this up but for your reference, Madam – says at paragraph 21 that you looked into her eye with some sort of scope for a couple of minutes. Did you do that?

A. I could well have used a retinoscope, and I do frequently use that during testing. I do not always note down my results from it. But it was not an ophthalmoscope.

Q. You did not use an ophthalmoscope?

A. No.

Q. Just to clarify, what is a retinoscope?

A. That piece of equipment will determine what her prescription is without actually having to ask her any questions. So if I shine the light in I will get an idea of what her prescription is. So it is a good starting block, so to say.

Q. Apart from the single episode of pain in the right eye, did she express any other pain?

A. No.

Q. Can you remember now whether she was wearing the new spectacles, or whether she was not wearing the new spectacles?

A. When she came in she was relating all of these problems to the new glasses she had collected four days previously.

Q. I think you looked into her eye – obviously you would have done to carry out some of these tests. Did you notice whether there was any redness of the eye, or anything like that?

A. Looking at her during the test I would have been this far away from her. So if she had a nasty red eye, or any red, I should say, I would have noticed a red eye.

Q. So in your clinical judgment, do you believe that you adequately assessed the patient, as she presented at that time?

A. I do, yes.

Q. Can I ask you, please, to look at the letter that you sent in, which I think is at pages 51-52 of your bundle, and can I take you to page 52 first, the third paragraph from the bottom:

"I sympathise with [the patient's] problems following an attack of acute glaucoma. However, the nature of acute glaucoma, as compared with chronic glaucoma, is of a rapid onset of symptoms. Having reviewed [the patient's] medical records, I note that on her visit to Heath Hospital in Cardiff on 6 November 2005 she reports an onset of symptoms of only one week."

Can you just help us with this, please? When you wrote "one week" as opposed to "1/7", what did you understand? Was it a misunderstanding, did you do it deliberately?

A. It was just a mistake. I was meaning to say that she had the red eye for one day and she had had symptoms of eye pain for three weeks, and I just got in a bit of a flap and put down "one week". That was all.

Q. Was it your understanding that in any event the hospital records went to the Optical Council? They had come from them, anyway, so that the Committee would be looking at those, when you wrote to them.

A. Yes.

Q. Can I just ask you to go back to the letter, just finally, in relation to page 51 and look at the fourth paragraph down, where it says:

"I reviewed Mr Davies' notes, which detail early lens changes, minor corneal changes (Fuchs' Dystrophy), CD ratios of 0.2, with the discs appearing shallow in both eyes. Her records showed the discs and macular to be healthy. I concluded that these notes were accurate and still relevant".

Now the allegation is that when you referred to Patient A's previous records indicating minor corneal changes, that that was inaccurate. That is what it says.

A. Yes. What I was trying to say and get across – my grammar is not fab – is that I looked at Julian's notes and was noting what I had seen, so it said she had had the suspect retinal tear, she had obviously been diagnosed with Fuchs' Dystrophy at some point, and that Julian had done an anterior eye

exam as well as a fundus exam. So I was sort of noting things that I had seen on his record card.

Q. In fact, that is exactly what you say. You say, "I reviewed Mr Davies's notes, which detail", the notes detail, "early lens changes and minor corneal changes (Fuchs' Dystrophy)".

A. Yes. So even though no-one had noted minor corneal changes, I was trying to say that I was translating.

Q. Yes, thank you very much.

MS MACKEN cross-examined by MR ALDER

Q. Ms Macken, just so that I can be clear, you answered very specifically to a number of Mr Stern's questions as to the examination. My note from the beginning of your evidence is that you now have no clear recollection of this patient's visit.

A. No. It was September 2005.

Q. There is no criticism. I appreciate that it is now some time ago. The symptoms which have been discussed at length, so the blurring of vision, the headaches, the pain centralised above one eye, would you agree with Dr Harper, indeed, with Mr Phillips, that those could be symptoms suggestive of an ocular abnormality of some description?

A. [Pause] Yes. I mean symptoms like that could be attributed to many things.

Q. Such as?

A. I am well aware that there are symptoms of glaucoma that would indicate this.

Q. What other ocular conditions could have these type of symptoms?

A. Off the top of my head right now –

Q. It is not an examination. I am merely trying to explore the range of –

A. If they said they had a red eye, then I would be thinking of other eye diseases like a uveitis. It all depends; it is the whole picture of the symptoms. It is not just they have done this, done this, done this, therefore it is that. It is the way they present the symptoms to me.

Q. So a patient who presents with, from your evidence, "blurred vision", as you have noted on your card,

"a reduced distance vision, headaches and pain right eye, 5 minutes",

that could be symptoms suggestive of potentially glaucoma?

A. I would not say so, because she did not specify that one eye was blurred. She said both eyes were blurred, and you would not get both eyes blurred in a subacute attack of glaucoma in one eye.

Q. But you recall that quite specifically now?

- A.** If she had said the right eye was blurred or the left eye was blurred, I would have written it down.
- Q.** Pain is quite specifically recorded as being just above the right eye.
- A.** In the right eye – well, I have written "pain right eye". I do not know whether she said just above to me.
- Q.** So the patient presents with what to you are new symptoms, because they are not recorded as at her result of her examination on 12 September, and I think it is clear, although if you could assist me, you did not perform a slit-lamp examination.
- A.** No.
- Q.** And you did not measure her intraocular pressures. Did you note at that time, can you recall, that there had been no measurement of her intraocular pressures on 12 September?
- A.** I would have read Julian's card in detail, so I may well have noticed that. I cannot recall.
- Q.** But you chose not to undertake that task during your examination?
- A.** It was not necessary.
- Q.** You did not, then, also examine further the ocular structures of her eyes?
- A.** Apart from looking at her, no.
- Q.** Given the symptoms that she presented with and from your evidence as well, that these symptoms could be suggestive of other ocular conditions, why did you choose not to perform tests which could have assisted you in coming to a more complete or full explanation for her symptoms?
- A.** I did come to come to a complete and full explanation. My decision was that it was the varifocals and the spectacle adaption that were causing those symptoms.
- Q.** Why did you not go on to consider those symptoms as potentially being suggestive of glaucoma, or a different ocular condition, as part of your overall examination of the patient?
- A.** Because I did not consider those symptoms to be glaucomatous.
- Q.** Would I be right in thinking that the only way you could come to that as a conclusion is if you have performed other examinations which could provide you with the information, the clinical information you would need?
- A.** Sorry, say that again.
- Q.** You said you did not consider the symptoms to be glaucomatous, but have in your earlier evidence agreed that the symptoms of pain, headaches and blurring vision could be indicative of other ocular abnormalities. How can you come to a conclusion that these symptoms were not glaucomatous, if you have not undertaken important tests which could have provided you with a fuller amount of information?

- A.** My job is to take the symptoms of the patient and translate that into a diagnosis, and that was my conclusion on the day, that it was the varifocals and the spectacle change. The symptoms she gave me did not indicate to me glaucoma.
- Q.** As an optometrist and a clinician what are your duties to the patient?
- A.** Duties? To perform an eye test, and to – it is hard to say. It varies day to day. I see a patient, and I test their eyes and check that they are healthy, and – I am not quite sure of your question, sorry.
- Q.** Do you agree with me that your role as an optometrist, as a clinician, is to undertake such examinations to determine whether there is any injury, disease or abnormality in patients' eyes?
- A.** If you are doing a full NHS or private sight test there are guidelines. In this instance I had a full test from the previous nine days earlier, and all those tests had been performed. Again, I am not sure about the pressures.
- Q.** But you are presented with a patient who is new to you, who is complaining of new significant symptoms.
- A.** They were significant symptoms and I concluded it was a spectacle adaption problem.
- Q.** You have referred to the patient complaining of pain, and that you often or sometimes come across that as a symptom for spectacle intolerance?
- A.** Yes. "Pain" is quite a widely used word in optometry. It is not a specific – I should not say that. Patients use the word quite frequently for different things. So it is my job to determine exactly what they mean by "pain".
- Q.** So a patient who in her own evidence presented to you and in her evidence recalls that she attended and told you of "piercing" pain, and pointed where it had been above her right eye –
- A.** She did not say "piecing", because I would have written down "piercing pain". She may well have put her hand in the right eye direction, yes. I do not know.
- Q.** But it is not common, is it, to have pain focused above just one eye, if it is to be a spectacle intolerance problem, is it?
- A.** It can be. That is the eye which had the largest prescription change, and a 1.5 dioptre change is quite difficult to tolerate.
- Q.** You said that you had undertaken a test of the fitting of the frames.
- A.** Yes.
- Q.** That was something that you had considered. You looked at the fit of the varifocals and presumably the centre of the lenses?
- A.** Yes, I would have made sure the varifocals had been glazed correctly into the glasses by the manufacturers, and then I would have put them on her and made sure that all those – the eye alignment was there. So you dot the centre of the varifocal and check it matches up with their pupils.

- Q.** Are you able to confirm from your record – clearly that is all we really can go on – that actually that centre point was accurate, that the fitting of the frames themselves was accurate?
- A.** I would think so, yes, although I cannot say for sure. But if I had noted that the heights were not correct in the glasses or the frame was bad, I would have written "Change frame, reglaze varifocals, back to manufacturers. Not happy with the prescription". Sometimes there is an inaccuracy in the actual making of the lens, and if I had seen any blemishes or problems, I would have sent them back to the manufacturers.
- Q.** But in respect of this check of the fitting of the spectacles, there was no problem with that? It was all accurate?
- A.** I may have made minor changes to the frame, in order to get the varifocal – often you have to tilt the frame more to get the whole varifocal channels and alignments there. So I may well have done that but nothing else, really, with regard to the prescription change.
- Q.** The evidence that you have given in respect of Allegations 2 and 3, about the accuracy of the recording and the note in your response, just so that I can be clear, are you accepting, therefore, that your response of 7 March in respect of the note of the hospital medical notes and the date of onset of the patient's symptoms, are you accepting that your response is inaccurate?
- A.** I made a mistake in the writing down one day, one week, three weeks yes.
- Q.** In respect of Allegation 3, the representation of the previous records indicating minor corneal changes, I think if my note is correct you refer to your grammar being poor, but are you accepting on that, that that was inaccurate?
- A.** My English writing is not the best. The chances are that my initial draft letter is not – yes. So what I was trying to say obviously did not get right down onto the paper copy. I was trying to say I had summarised Julian's notes in my mind, and I think I just did not quite get it written down properly.
- Q.** Just very briefly, Ms Macken, you will have possibly seen the response of Mr Phillips that he provided to the General Optical Council. Did you have an opportunity to look at that?
- A.** I have it here and I have read it, yes. What do you mean?
- Q.** I just wonder, as you will understand from the two allegations, why the responses are in respect of those matters identical between both yours and Mr Phillips' response.
- A.** Are you referring to that one paragraph, or the couple of paragraph?
- Q.** Actually the paragraph in respect of –
- A.** It is the whole response, is it not, saying –
- Q.** In respect of the review of the notes, also in respect of the sympathy you have with the patient, but also the review of the medical records as to her visit on 6 November 2005. I just wonder if you could explain why those two responses are so similar, if not the same.

A. They are similar because I had assistance in writing this. As I said, I wrote rambling – this is like a legal document. If I had written it, it would have been a bit -. I wrote my draft, and wrote down everything I was asked to write down, and then I had help with putting the letter together. I assume that is allowed.

Q. I just wonder if this is your independent response given to the General Optical Council. That is either a "yes" or "no" answer.

Mr Stern: Can I just interrupt for a moment, because we are straying into areas of legal professional privilege. If I could just speak for a moment and then you will be able to respond. The position is, as Mr Alder knows full well as this cropped up in a previous case, what happens, perhaps not necessarily the best way to do it, but that is what happens, is that the practitioner obviously contacts the AOP, which are the professional body, which they are duty bound to do, to notify them that there is a complaint, and as Ms Macken said they get assistance with writing the letters. I think beyond that, it is perhaps a matter for the AOP to answer, not for Ms Macken to answer, and one has to be a little careful about straying into areas of advice that she has been given by legal advisers. That is all I am saying.

Mr Swinstead: Mr Alder?

Mr Alder: Sir, when Ms Macken is answering questions as to the response which she says she has signed and she has sent to the Council, it is important, I suspect, for the Committee to be clear that that is actually her response and that there is no intention later on in these proceedings to say, "Well, actually that wasn't mine and I didn't write it". I think it is fair to Ms Macken –

A. I agreed with what was written here and signed it. Is that what you mean?

Q. It seems unusual that you would have two responses exactly the same. That is the point I was clarifying with Ms Macken. That seems an appropriate course of action and an appropriate series of questions.

A. I was not aware of Hugh's response when I signed and sent mine off. I was only aware that Hugh's was the same as mine on getting the bundle from you.

Q. Thank you. But you were happy with the response that you sent? You checked it and you were happy with the accuracy of it before it went to the Council?

A. Yes. As I said, to do with the Fuchs' Dystrophy, that is me and my grammar. I thought that sounded fine to me. If I had known that you were not happy with the minor corneal changes, then I would have changed it, and if you had queried it, I would have said, this is what it is, it is nothing intentional. The "one week" bit is just an oversight on my behalf, and to be honest, I was quite distressed at the time. To me this is a big thing.

Q. I appreciate that. It was just important to clarify that point. Thank you, Ms Macken. Thank you, Madam.

[Pause while Mr Stern takes instructions]

Mrs Hallendorff: Mr Stern, do you have some more questions?

Mr Stern: I was just discussing a matter with my instructing solicitor. I am just slightly concerned that Ms Macken will leave the witness box without knowing what the Optical Council's case is in relation to what the central point is. The central issue, in my submission, is whether or not the question of presenting pain as a symptom by the patient is reasonable to conclude that can amount to spectacle intolerance. That is the central issue, in my submission, and I think Dr Harper would agree.

Now I do not know whether or not the Optical Council are suggesting that Ms Macken has never seen a patient with pain before that has been due to spectacle intolerance, or that the pain – Dr Harper said that he had never seen a patient with pain, and I assume that is the case for the Council. If that is the case, then Ms Macken ought to have that put to her.

Mr Swinstead: Mr Alder, what do you say about that?

Mr Alder: Madam, I apologise to you and to my learned friend. I was actually at the point when Mr Stern completed his submission seeking further clarification from Dr Harper, because certainly in my note and Dr Harper's recollection, that was not his evidence, and it seems to be quite an important central issue. Dr Harper's evidence was that he had never seen a patient with pain in one eye due to spectacle intolerance, not that he has never seen a patient with pain.

As for the rest of Mr Stern's submission, Madam, I apologise, because I did not catch it in time. There seemed to be an issue as I understand it that the Council has not properly put its case in some way. Again, I am slightly confused; I thought the case had been put quite clearly both to Ms Macken as, indeed, to Mr Phillips.

If it would assist the Committee, I can ask further questions. I was hoping not to do so. I am conscious that it is a very stressful time for the witness. But I can put the Council's case very clearly to her, if that would be felt appropriate by the Committee. I felt that the Council's position and case had been quite clearly put and Ms Macken given the opportunity to answer to it.

Mr Swinstead: Thank you, Mr Alder. Mr Stern, you have heard what Mr Alder says. I think it is fair to say that the body of Mr Alder's cross-examination followed essentially the allegation, obviously concentrating particularly on the issue of "the pain" and whether Ms Macken thought she ought to or should have taken other steps to investigate that pain, and I think she has given her answers as far as that is concerned.

Mr Stern: I would agree.

Mr Swinstead: That in a sense is how Mr Alder conducted his examination, and with respect, I am not sure what the problem therefore still is. He has made it

clear that a base point – sorry, I am putting words into your mouth, Mr Alder, but your base point was: "She presented with these symptoms, which included pain over one eye. Did you not think that you should have carried out certain further investigations to cover other possibilities?" which I think Mr Alder by inference is saying a reasonable optometrist would have done. Now I think that is how he was putting his case. He may not have put it in those words in cross-examination exactly.

Mr Alder: I do not think I did, but indeed.

Mr Swinstead: No, but that is I think what he said, and that, with respect, is his – has he not put his case?

Mr Stern: No, with respect. That is not the case. All that is is the possibility that certain other things might have been done, and as I have been at I hope pains to point out yesterday, the test is not should a few other things possibly have been done. That is not what a disciplinary hearing is about, in terms of an allegation of failure to carry out various things. The allegation of failure to carry out various things is whether or not no reasonable optometrist, in this case, would have omitted to act, or done, or come to the conclusion that this practitioner did. That in my submission is the test.

Now that is based entirely on Dr Harper's evidence. My recollection of Dr Harper's evidence, and we will try to find it in due course, is: "I have never experienced a patient who has had pain from non-tolerance of spectacles" – I am paraphrasing, not quoting him exactly, but that is my understanding of his evidence – "and because I have never experienced that, the position is therefore that further tests should have been carried out", because pain was not attributed to spectacle adaption.

So if it is the Council's case that no reasonable optometrist would have done that, then it must follow that Ms Macken has either not seen patients with pain before as a result of spectacle adaption, or, if she has, then in this particular case it was completely inappropriate. But that is not the way the Council have put their case.

Mr Swinstead: We are getting a bit off, because I am aware that you are using a particular phraseology, which I was actually going to deal with, because you very kindly put the case of *Doughty* in front of me, and I hope you have given –

Mr Stern: Yes, I have.

Mr Swinstead: And I was not intending to get into that issue at this stage. It seems to me that the way in which Mr Alder has put his case, I use the word "neutrally" for better or worse, it is his case, what he is saying is that Ms Macken, faced with what Patient A indicated were her symptoms, should have undertaken further tests, in simple terms. Dr Harper has given his own experience, but that would be with respect a matter for the Committee, to decide whether or not Dr Harper's evidence, upon which Mr Alder has based

his cross-examination, with respect – the question for the Committee essentially is whether Ms Macken should have taken other steps, or whether as a reasonable optometrist, bearing in mind what Dr Harper has said, she performed properly given the symptoms of the patient. Now that in simple terms is the issue. I am not sure that Mr Alder can put anything further. [*To Counsel*] Sorry, I hope I am summarising your case fairly.

Mr Alder: Sir, indeed. That has been the Council's case throughout. It is the case that I put to Ms Macken. The Council does rely upon the expert opinion of Dr Harper, who in addition to the issue of pain talks about the context of this patient's presenting symptoms. The issue is not just pain, it is wider than that.

But the Council puts its case, and must do in these cases, on the basis that the patient gives a certain degree of information and evidence, expert opinion is sought, and the determination then is a matter for the Committee, as to what steps should have been taken by a reasonably competent optometrist. In this case the Council's case is clearly put, that additional examinations should have been undertaken to have given the baseline information. The Council is not saying that it is impossible, and that it is not possible for this patient to have had a spectacle non-tolerance issue. The Council's case has been throughout that that may be an answer, but that there are other answers potentially. That is what the other tests were there to prove.

Mr Swinstead: Mr Stern, that is certainly what I have understood Mr Alder's case to be, and I think he has put that case to Ms Macken, and I do not think it is necessary for him to put it in any further. What the Committee make of it is entirely a matter for the Committee.

Mr Stern: I will make representations in due course. If Mr Alder does not feel that there is anything more that he wants to put, but I do not respectfully feel that that is the position, when one analyses the evidence carefully.

Mr Swinstead: Can I raise another issue while Ms Macken is here, because there may be further questions – Madam, if I might raise a different issue?

Mrs Hallendorff: Yes, please do.

Mr Swinstead: In the light of Mr Alder's cross-examination of Ms Macken, on Allegations 2 and 3 in the allegation, there is or may be an issue, and I do not know whether either want to pursue it further, because it seems to me that what was being suggested and I think Ms Macken has essentially agreed is that she wrote out as it were her explanation, but she then received some assistance with the wording of the final letter, and albeit that she has accepted it and obviously it is her document, the inference of what she was saying was that somebody else had prepared the document which she signed. With respect, I do not know whether you want to pursue that further with her, Mr Alder, because you put your case I think at the beginning that if that was her misunderstanding, then that may go to a whole question of deficient performance, if she was actually misreading in the first case hospital notes and the second case Mr Davies' notes.

It seems to me that an issue that the Committee may have to decide is how much whilst the letter is hers the responsibility for any errors is hers, and how much it is that of the person or persons who may have assisted her in preparing the letter. If it is the latter, it may be more difficult, with respect, to go on to say therefore her performance must be deficient because she has done no more than sign a letter which contains inaccuracies, which she has accepted by signing the letter, but which she may or may not be directly responsible for.

Mr Alder: Sir, the purpose, indeed, of my questions to Ms Macken on that point were to establish that. Ms Macken accepted that it was her letter and that the errors were hers and that is my understanding of her evidence.

Mr Swinstead: I am only concerned that there is not therefore going to be any issue, Mr Stern, that in some way this was not her document and therefore the errors were not –

Mr Stern: Well, she said it and she signed it, so it becomes her document.

Mr Swinstead: But there is a specific issue because it is the follow-on of the deficient performance question. That is all I was concerned about. Thank you.

Mrs Hallendorff: Mr Stern, do you wish to re-examine?

Mr Stern: No, I have no re-examination, thank you.

Mrs Hallendorff: Mr Baldwin, do you have any questions you wish to ask?

Mr Baldwin: Yes, I do.

The statement of the patient makes it clear in more than one place that the pain which she describes as "shooting" or "piercing" was not in an eye, but above an eye. What do I make of that?

A. She never said she had "shooting" or "piercing". She had different wording in her two different statements.

Q. And the significance of her saying that the pain was not in either of her eyes, but above her eye, what difference would that make?

A. I think again if she had said, "I've got pain above my eye", I would have written "Pain above eye". I cannot say exactly what she said, but she would have said "I'm having pain in my right eye". I tend to really write down what they tell me, because that is an important part of taking symptoms, you write down what the patient says. I do a note.

Q. I am a lay member of this panel, and I do not know whether there is any significance. A lay person might think that a pain in the eye is related to the eye and a pain above the eye is related to a normal headache.

A. It can be a normal headache, but again, a pain above the eye could well be a muscle problem within the eye. So I have performed a test to check the muscles of the eye. But often with an eyeball you cannot specify exactly where pain is sometimes. That is the way the eyes are. You might say it feels like the pain is here, but often it is something else.

Q. The reason I ask is that she also says in her statement that she was able to put her finger precisely on the point above her eye, not in her eye, where the pain came from.

A. I do not recall that, but then I might have just taken her actions as just pointing to her right eye. She did not specify, "It's above the right eye", she would have said "pain in right eye". I do not know whether she touched her brow or not.

Q. Thank you.

Mrs Hallendorff: Mr Reily?

Mr Reily: Obviously I am very familiar with the problems you can have with varifocals. Can you recall if the patient presented with her previous spectacles when she came in for this check?

A. When I saw her she did not have her glasses on her, because again, I normally take accurate measurements of previous glasses. So she might have had them, but I am pretty certain she did not come with the glasses. But then, she had not booked in to see me. If she had come in saying, "I need to see an optician, I'm having problems", I would have said, "Right, bring your glasses in. Book in". But I just had a lady is coming in to have her glasses fitting assessed.

Q. It is just curious that she does say that she only manages to wear them for two hours per day, and I would suggest that with a correction like that she would wear spectacles all the time anyway.

A. I assume she was still using her old ones maybe. Later on she does say that she chop and changes between her glasses quite a bit. But I do not know. Again, the unaided visions that Julian has written down do suggest that she would be a bit lost without her glasses.

Q. Yes! I could not find anywhere in any of the record cards what the readings were with her previous prescription.

A. As she did not have the glasses with her with me, I do not know. But again, Julian has not noted them down. He might have measured them but he has not noted them down.

Q. Thank you.

Mrs Hallendorff: Mrs Huka?

Mrs Huka: Ms Macken, do you remember the distinction between somebody who has been wearing varifocals and somebody who has just started to wear varifocals, when you are looking at spectacle intolerance?

- A.** Definitely with someone new to varifocals you would need to take more time to explain how the varifocals work, and often you have to reiterate this, so it could well be just they need time to discuss, "Hold it here, hold it here, this is how varifocals work", and you do give them a lot of information at the first dispense. So it might take a second dispense just to reiterate exactly how a varifocal works, but that is normally done at the collection. But generally if they have worn varifocals before, I would expect them to know their head positioning and roughly how they work. But as I said, each varifocal make is different, so again, I would say it does take time. Anybody in varifocals I do say it does take time to get used to them for the new positioning and the new prescription.
- Q.** So in Patient A's case, where she had been on previous varifocals and was complaining of pain on this occasion, would you not consider that maybe there are other things, other than spectacle intolerance, that should be investigated as well?
- A.** At the beginning I would have considered quite a few possible problems, but then from the symptoms she gave me my conclusion was that it was a spectacle adaption. Her symptoms led me to that conclusion.
- Q.** Although she had indicated that her previous varifocals were OK, i.e. she did not have a problem with varifocals *per se*?
- A.** These problems were with the new varifocals, yes, she collected the new varifocals four days previously then she was having these problems with the distance visions blurred. So that is the conclusion I came to. With varifocals for four days it is quite common to have adaption problems.
- Q.** Thank you.

Mrs Hallendorff: Ms Viner?

Ms Viner: Ms Macken, I have a couple of questions. I just want to ask for some clarification on the record card, your record card on page 11. At the top on the right-hand side, just to the left of the date stamp, you have written "Variable" and I think that is "right greater than left"?

- A.** Yes.
- Q.** Could you just explain what you meant by that, please?
- A.** These are notes of the test, I know how the test went, so that means that during the test I found her right eye more difficult to pinpoint the exact prescription. I am not saying that she was giving me wrong answers, but her answers would have been more vague in that eye. So if I had seen her at a future date, I would have known to take her right eye a little bit slower, perhaps use bigger differences in my testing methods and things like that. So I often write "variable prescription" or "variable subjective" to give me clues for future tests and if she comes in I know what I have done.
- Q.** So that relates to the actual finding in the prescription rather than the visual acuity?
- A.** Yes, that is the actual test, how my test went.

Q. Thank you. Then just one more question, just picking up on the question that my colleague, Mr Reily, asked. The timing of wearing the new varifocals is very specific in your records here, four days for two hours each day. Would that be something in your recollection that the patient had chosen to do, or would that be a recommendation made at the fitting, also at the collection stage, that a dispensing colleague may have said, "Just try for two hours per day to build up wearing them?"

A. No, I myself would say to someone with new varifocals, "Once you get home, put them on and leave them on, don't chop and change", in fact – I do not know what I said to her, but I might have said, "You've got to persevere more with them". The new ones mean she is having a vast jump in her prescription, pretty much every day. So I am not surprised if she was struggling if she was going between the two. But we did not request her to do – as far as I know, it is not good practice to request they do it gradually.

Q. Thank you.

Mrs Hallendorff: Ms Macken, at no stage it appears did she say to you that she preferred her old glasses.

A. Not to me.

Q. Not to you. She subsequently said it to your colleague, but to you she did not tell you that she preferred the old glasses at any stage?

A. No.

Q. Thank you. Mr Swinstead?

Mr Swinstead: No, I have no questions. I do not know whether either party has any questions.

Mrs Hallendorff: Do you have anything further to add? [No] Thank you, Ms Macken.

[The witness stands down]

Mrs Hallendorff: Mr Stern?

Mr Stern: May I call Dr Eperjesi?

**DR FRANK EPERJESI called and affirmed
Examined by MR STERN**

Q. Madam, you have the reports of Dr Eperjesi in the bundle between pages 1 and 15 in relation to Ms Macken and pages 16 to 28 in relation to Mr Phillips. Can I first of all deal with Ms Macken, and if you look, please, at page 13 of the report, you will see the curriculum vitae of this witness. Perhaps you could just run us through that, please, Dr Eperjesi. I do not think we need the school, but we can see that you qualified as an optometrist in 1990-91.

A. Yes.

Q. We can see your clinical professional experience half-way down. In 1991 to 2007 you say 16 years post-registration experience in primary care optometry practice. Just help us with that please, what does that mean?

A. I did my training at the Birmingham Midland Eye Centre between 1990 and 1993. On Saturdays I spent my time working in high-street practice in those years to 1995. In 1995 I left the eye hospital and became a full-time locum, where I spent about four days a week working in independent practice in multiple practice and the other two days a week doing research and teaching at Aston University. I had a six-day week in those days.

Q. It is lucky it was not seven.

A. Yes! So that was between 1995 and 2000. As I say, I was spending two days a week at Aston University teaching and doing research. In 2000 I completed my PhD and then gained a full-time position at Aston University. Since then I have been a lecturer at Aston University, but also in 1999 I became a partner in an independent practice in Newport, Shropshire. So I have also been working Saturdays in independent practice and some time during my holidays from the university in independent practice as well.

Q. We can see below that the publication of articles and textbooks and your teaching, etc.

A. Yes.

Q. And the present posts are all set out there, as well as your qualifications and your membership of learned societies. I will not go through the rest of those. Can I ask you to turn back, please, to page 12? You have recorded there under "Statement to the Disciplinary Committee":

"I understand that my duty is to the Disciplinary Committee and I have complied with that duty."

What do you mean by that?

A. I understand my role in compiling this statement and also my role here today is to help the Committee to reach a decision. So not on anyone's behalf, as it were, I am here to help the Committee to reach a decision.

Q. Underneath you have put a declaration of truth:

"I believe that the facts I have stated in this report are true and that the opinions I have expressed are correct."

Is that right?

A. Yes.

Q. Can I take you back, then, please? I want to ask you about Ms Macken, and we will begin if we can at page 3, and look at 21 September 2005, which is page 11. Can I just ask you in terms of headline before we go through, you have heard Ms Macken's evidence and you have set this out at the synopsis

on page 3 at paragraph 1.2? Essentially, she concluded in her clinical judgment that the patient's symptoms were as a result of adaption problems to the new varifocals.

A. Yes.

Q. What is your view of that, please?

A. I would have come to the same conclusions, I have no doubt.

Q. If you had been at the practice at the same time, what do you say you would have done?

A. Once the patient had reported to me that she was having some difficulties, I would have inquired as to what they were. I would have made a note of them, and if I had received the symptoms that Ms Macken received, I would have looked at the fitting of the glasses, I would have checked the accuracy of the lens power, and having found that the lens power was okay and that the visual acuities were okay, I would have instructed Patient A to persevere a little while longer in wearing the varifocals; and in a similar way to Ms Macken I would have said, "If your problems have not resolved within a couple of weeks or so, then please come back and let me know". That is my standard practice.

Q. Can I ask you about pain and new spectacles? Is that something you have come across before, as a high-street optician or indeed anywhere?

A. I have come across patients complaining of pain, yes.

Q. Regularly, or hardly at all?

A. In the context of they are not getting on with glasses, or in a general context?

Q. Sorry, not getting on with glasses.

A. Not getting on with glasses. It happens. In my experience it is not a common complaint for patients to make when they are not getting on with glasses, but it is a complaint that patients make.

Q. Are you familiar with Kodak varifocals?

A. Yes, I am.

Q. What is your practice's position in relation to them?

A. The practice that I am a partner in opened in 1999 and we tried Kodak varifocal lenses for a short while, and found that we were having non-tolerance problems with them that we felt were due to the way the lens is made. So we do not have Kodak varifocal lenses in my practice any more.

Q. Can I now take you to the opinion that you have given in relation to the allegations, which begin at page 5? At the foot of the page you have GOC Allegation 1(i), the failure to perform a slit-lamp examination. What is your view about that, please?

A. I think that a reasonable body of optometrists would not have carried out a slit-lamp examination with this type of patient presentation with those type of symptoms.

Q. Over the page, please, at page 6, likewise the IOPs, the intraocular pressures? What do you say about that?

A. Again, with this type of patient presentation, I do not think a reasonable optometrist would have carried out intraocular pressure measurement.

Q. Your opinion in relation to all of these is as a result of what?

A. My opinion is based on my own personal experience of working in primary care optometry practice, and also working with many other optometrists in that primary care environment, and listening to how they tackle this type of problem. Also I have a close circle of five optometry colleagues, who work in many different areas of optometry, and when I am asked to be involved in these cases I ask their opinion – anonymously, of course, not mentioning any personal details – as to what they would have done in this type of situation. So my opinion is based on my own experience and on the experience of colleagues.

Q. Allegation 1(iii), that she

"did not undertake ocular investigations to try to identify the cause of her symptoms",

what do you say about that?

A. Ms Macken had made a clinical judgment that this patient's problems were down to the glasses. She had made that judgment, and therefore I do not think there was any need to do any other tests, over and above the ones that she did at this re-check assessment.

Q. So the first point is, as you have put there, that using her clinical judgment

"she concluded that the problems experienced by patient A were due to her new varifocals",

and you say, "This is a reasonable conclusion to make".

A. Yes.

Q. Do you stick by that?

A. Yes.

Q. And if that is a reasonable conclusion, is it then not necessary to carry out the other tests? I appreciate that is a double negative, but you know what I mean.

A. Yes.

Q. Not need to carry out further tests.

A. Yes. As an optometrist, once you have made a judgment and a decision as to what is the cause of the patient's symptoms, then you do not make any other tests. You have concluded, you have reached your endpoint, and then you deliver your conclusion to the patient.

Q. Allegation 1(iv) is that

"Ms Macken did not determine an explanation for her presenting symptoms".

A. Well, she clearly did. She did determine an explanation. Her explanation was that this is a non-tolerance to the new varifocal lenses.

Q. Then on page 7 of your report you deal with the symptoms, which you say

"could be due to any of several factors ... fitting of the frame ... type of varifocal lens used. There are many different types of varifocals",

which I think goes back to the point that Mrs Huka was making before, that just because a patient has been wearing varifocals, does that mean that she or he is likely to be more tolerant or less tolerant, or does it not matter?

A. It does not matter, especially when there is a change in the prescription. Any subtle change in varifocals in terms of lens power, lens size, the frame details, lens positioning, all of those sorts of things can result in a non-tolerance, even for a person who has been a successful varifocal wearer for many years. I have personal experience of these types of cases.

Q. You then say,

"Symptoms associated with near work such as eye pain or ache and frontal headaches may also be due to eye alignment ... problems",

and you set out there that she looked at the fixation disparity.

A. Yes.

Q. Which is the appropriate test for that is it?

A. It is one way of checking for eye alignment problems. It is an appropriate test, yes.

Q. You deal in your following paragraph with primary angle closure glaucoma being a very rare condition. Would you expect a reasonable optometrist to consider glaucoma, or particularly this type of glaucoma, with the symptoms that were presented by Patient A on 21 September?

A. No, I would not.

Q. Obviously when a patient presents an optometrist has in their tool-box, if I can use that expression, a considerable number of possible tests. Is it necessary for an optometrist, particularly in doing a re-check here, to do all of those tests? For example, should she have done – I do not know if it is suggested she should have done – field tests?

A. No. Especially at a re-check examination, the tests that are carried out depend on the presenting symptoms. So, you tailor-make your re-check examination according to the presenting symptoms?

Q. So does it fall, then, to be determined by the clinical judgment of the practitioner seeing the patient at that time?

A. Yes.

Q. You then deal with intermittent angle closure glaucoma, and I think there does not seem to be any dispute about that. Then at the foot of page 7, you say,

"Given the nature of the symptoms and that the previous full eye exam had taken place less than two weeks earlier ... by a senior and more experienced optometrist, I think that is a reasonable conclusion to make. Symptoms such as eye ache or pain and frontal headaches are far more likely to be caused by spectacles especially if they are new than a condition as rare as intermittent angle closure glaucoma."

You then say,

"I have no doubt in my mind that a reasonably competent optometrist would have made the same clinical judgment as made by Ms Macken on 21 September 2005."

Is that your opinion?

A. Yes.

Q. Then you deal with part of paragraph 29 in the statement of patient who says that over a three-week period when she had been wearing her old spectacles, she had not suffered any problems. I am paraphrasing paragraph 29, but that is essentially I think what she says.

A. Yes.

Q. What is your view in relation to that?

A. If symptoms are resolved in wearing glasses or old glasses, then those symptoms are very unlikely to be due to an eye disease. If you can get rid of symptoms by wearing your old glasses, then that suggests that there is something not quite right with the new glasses.

Q. Then Allegation 1(v) on page 8,

"Ms Macken did not examine the ocular structures of her eyes",

your view on that, please?

A. There was no need to assess the ocular structures of the eyes, because the ocular structures had been assessed two weeks earlier, and the symptoms were as I say highly indicative of a spectacle intolerance or non-tolerance problem rather than an eye disease problem.

Q. Over the page at page 9, Allegation 1(vi), that "Ms Macken did not adequately assess her presenting symptoms"?

A. Well, she did, because she made a note of the symptoms, and she carried out a lens check, re-checking the prescription. She did some muscle alignment testing, and she gave the patient some advice.

Q. Then Allegation 1(vii), that an adequate record of the examination was not completed, I think Dr Harper agreed that if it was a re-check and the

conclusion is right, or might be right, it was accurate, then the tests that were carried out were adequate, and also obviously the patient record card, it is obviously only if something more should have been done. So I think it follows from your other evidence that the patient record card was adequate.

A. Yes, I think it was.

Q. The second allegation, again we are not entirely clear about that, the 1/7, 3/52, is that an error that – we know that Dr Harper made it, so I suppose it is an error that other people could make.

A. Yes, and it is an error that I have made in the past, and it was something I was particularly not keen on repeating in my statement, so I did focus on that, to make sure that I understood exactly what the 1/7 and to a certain extent the 3/52 meant. But I can easily understand how that could be misinterpreted, miswritten or there was some error made with that.

Q. In relation to Allegation 3, it says there is a reference

"to patient A's previous records indicating minor corneal changes which is inaccurate",

and I think the previous record is 12 September. Fuchs' Dystrophy: can that be described as being minor corneal changes? I think Dr Harper has already agreed this, but I will ask you for the sake of completeness.

A. Yes, it can be.

Q. So is there anything else that you want to say in relation to Ms Macken? We have your report here and I know the Committee have read it, but is there anything else in relation to Ms Macken that you feel it would be helpful to add?

A. No.

Q. Can we turn then, please, to Mr Phillips, and look if we may at 10 October, which is the date that he saw the patient. At page 18 you set out a synopsis of the action taken by Mr Phillips on 10 October. Again, can I ask you just to headline the point before we look at the detail? As we know, Mr Phillips concluded that the patient was having difficulty with her varifocals and that, as he has written on the record card, there was a non-tolerance in adapting to those spectacles.

A. Yes.

Q. Is there any difficulty in relation to that? I apologise, he did not write that. That is a mistake I made. I think he said that that was written by somebody else. "Returned as non-tol" was written by somebody else, on the right-hand side. But that was his evidence. Again, can you just help the Committee, overall is that a reasonable conclusion or not?

A. Again, based on the patient's presenting symptoms, I think his conclusion was a reasonable conclusion to make.

Q. And again, if I may ask you personally what you would have done?

A. I am very certain that I would have done, and I have done in these sorts of cases, exactly the same thing as Mr Phillips did.

Q. I think we can turn to the allegations at page 20. Again, I think we can probably take this relatively shortly, bearing in mind your evidence in relation to Ms Macken. But the first allegation, Allegation 1(i), performing a slit-lamp examination, your view as to whether that should have been carried out on that occasion?

A. I do not think it was necessary to carry one out, but it seems that one was carried out.

Q. When you say it seems as if one was carried out, what is it that draws you to that conclusion?

A. It was not desperately clear from the notes when I first received them whether a slit-lamp examination had been conducted. So I asked Mr Phillips whether he had done a slit-lamp examination via the AOP, and the response from Mr Phillips was that he had carried out a slit-lamp examination on that day. Since then I have learned that the words underneath "LOBE", the "see" and something "LSBE", the first two letters were cut off, and since then I have learned that that is "Fuchs both eyes". So that again also suggests to me that a slit-lamp examination was carried out by Mr Phillips.

Q. Allegation 1(ii), failed to "adequately identify an explanation for her presenting symptoms"?

A. He made the judgment that there was a non-tolerance to the new lenses.

Q. And you say at page 20,

"The symptoms of eye pain or ache after near work along with frontal headaches often occur with the use of new glasses including varifocals".

Do you stand by that evidence?

A. Yes.

Q. Can I take you to the foot of page 21, please, because obviously a lot of what you have written in the middle of page 21 is the same as for the previous report and I do not want to repeat that? But this specifically deals with Mr Phillips and you record there that he increased the reading prescription. Just help us with that, please.

A. The reading prescription issued by Mr Davies was a 2.25 addition lens, and I think Mr Phillips made the decision that this was perhaps too low a power, based on the patient's presenting symptoms that she had some problems with near vision, and also – again, this is something that I had not managed to decode, this phrase "preferred old RX for near", I had not decoded that until the hearing. I was not aware of what that said until this hearing had started. But anyway, based on the fact that the patient was presenting with some problems at near, and based on the fact that Mr Davies had made quite a substantial change to the lens power – Mr Davies' change resulted in the near prescription being reduced considerably – I think it was sensible for Mr Phillips

to try to get the reading power to be closer to what it was before Mr Davies had made a change. I think that was a sensible approach, because the patient was complaining of a near vision-related problem. I believe that even more so, having now become aware of what that other phrase is, "preferred old RX for near". Of course, Mr Phillips would have had that information when he made his clinical decision.

Q. Moving on to page 22, Allegation 1(iii), "did not perform an examination of near visual acuity", you make a criticism of somebody for not doing that, I think, but we have heard evidence from Mr Phillips that he did carry out that examination, and obviously it is a matter for the Committee as to whether they accept that or not, but there is no record of it.

Mr Alder: I wonder, purely because this is a question session, if you could ask the question of Dr Eperjesi rather than just comment?

Mr Swinstead: Sorry, I do not quite understand, Mr Alder. What is the problem?

Mr Alder: Mr Stern has just tried to repeat the evidence given by Mr Phillips without putting any form of question to Dr Eperjesi. Perhaps I have missed something fundamental. I thought we were in examination in chief, which is a series of questions to be asked of Dr Eperjesi, rather than a point at which Mr Stern may make –

Mr Swinstead: I think with respect in this particular case, I am not going to put words in Mr Stern's mouth, but I think he was in effect thinking aloud, which is "I can't deal with this, you make a point, the Committee has heard the evidence, therefore we go on" and perhaps that is not in the form of a question. There appears to be a certain tension between counsel, if I can put it that way, as to whether people are formally asking questions, but in this case I think all Mr Stern was doing was simply thinking aloud and moving on to the next point, because quite clearly, as he said, it will be a matter for the Committee to decide and therefore really nothing Dr Eperjesi can say. So with respect, I think on that particular occasion perhaps Mr Stern should not have been thinking aloud, but I do not think it is a matter which as he moves on to the next point requires the Committee's intervention or, indeed, necessarily criticism of Mr Stern.

Mr Stern: Allegation 1(iv), on page 23, "did not complete an adequate record of the examination"?

A. I think it would have been more complete if the visual acuity had been entered.

Q. How significant is it to have omitted the record of that?

A. To some extent you can determine the level of near visual acuity by having knowledge of the distance visual acuity, in this case 6/9 and 6/6-, which is highly suggestive that the near visual acuities would have been in the normal range. But it is an omission. I think a reasonably competent optometrist would have noted the near visual acuities, but I think it is a slight omission.

Q. I am not going to ask you about Allegations 2 and 3 again. Those are all the questions I have. Thank you very much.

DR EPERJESI cross-examined by MR ALDER

Q. Dr Eperjesi, you referred to your curriculum vitae and say that from 1999 you were an independent – is that an independent partner or independent practice in Shropshire that you were a partner of?

A. An independent practice.

Q. That is at the same time as your full-time teaching and research programme at Aston?

A. Yes.

Q. Just for clarification, how much actual practice do you engage in? Are you there once a week, twice a week?

A. Most Saturdays, and some periods in my vacation time from the university.

Q. Just to clear up a point that you mentioned in chief, at the back of both of your reports, for example, page 15, you refer to a list of documents which I had anticipated were those matters which you had taken into account when preparing your reports.

A. Yes.

Q. You do not mention in any of your addenda or documents that you have sought direct information from either of the registrants. Is that something that has happened in both of your reports?

A. No. The only clarification I sought was about whether Mr Phillips had used a slit lamp or not.

Q. Because it was not clear to you from the record that a slit lamp had been undertaken?

A. It was not clear to me from the record or any of the statements I had read that a slit-lamp examination had taken place. But as I say, it was not a direct contact, it was through Mrs Mitchell.

Q. You are at Aston now. Does that involve hands-on teaching of undergraduates, post-graduates?

A. Undergraduates mainly.

Q. You will be clearly aware that this is a public hearing. A transcript of the entire hearing and your evidence will be available to the public. Is this type of case, these cases, case scenarios that you could use for your students?

A. Are they case scenarios that I could use? I think we could use them in our teaching, yes.

Q. You would be happy for your opinion to form part of the basis of your teaching to those students?

A. Yes.

- Q.** So Patient A presents before you as an optometrist. In the scenario given by the patient, she reports piercing pain, a reduced distance vision and headache and pain. Your conclusions as an optometrist and your reasonable opinion today is that you would not perform any additional tests beyond those performed by Ms Macken?
- A.** I think an interesting word there is "piercing". If a patient reports to me with piercing pain, then I could well have done different tests.
- Q.** So you accept that if it was the patient's evidence, then you would have performed additional tests?
- A.** It is likely that I would have performed additional tests. If that word "piercing" had been in the symptoms, then it is highly likely that I would have done other tests.
- Q.** What about "shooting" pain?
- A.** I think I may have done other tests for shooting pain as well.
- Q.** Why?
- A.** I guess shooting pain and piercing pain and those sorts of words to describe the pain would have heightened my index of suspicion that possibly something else was going on.
- Q.** Such as?
- A.** Shooting pain is suggestive of a dry eye, for example. Also piercing pain is suggesting of dry eye. That is one problem that comes straight to my mind.
- Q.** We have discussed between us and with the Committee generally the symptoms of this patient. Would they possibly be indicative of other ocular abnormalities, other ocular diseases?
- A.** Possibly, yes.
- Q.** Again, you heard the question I put to Ms Macken, what type of ocular abnormalities or diseases would you be thinking of as an optometrist?
- A.** With a presentation of pain?
- Q.** With a presentation by this patient.
- A.** With which symptoms; the symptoms in the patient's statement or the symptoms in the registrant's?
- Q.** I just note in your report you have not referred to the patient and her evidence.
- A.** No.
- Q.** Let us firstly go with what the patient tells us in her statement.
- A.** If the patient had presented with the symptoms that are in her statement, then it is very likely that I would have carried out other tests. I would have been looking for an eye alignment problem, a dry eye problem, some sort of inflammatory problem, perhaps, inside the eye, those sorts of things.

- Q.** Would you have been concerned about one of the glaucomas with these symptoms?
- A.** The symptom of pain is associated with closed angle glaucoma, but the classic symptom of certainly intermittent glaucoma is haloes around lights. Now if someone says that to me, then I am highly suspicious that there is some intermittent angle closure glaucoma going on. That is a classic symptom for that. Pain on its own would not immediately point me in the direction of any glaucoma.
- Q.** What about pain allied to blurred vision, reduced distance vision and headaches? Would that raise your index of suspicion?
- A.** It would do. But I do not think it would still point me in the direction of glaucoma.
- Q.** But it would presumably point you in the direction of undertaking additional tests to confirm that it was not one of the glaucomas?
- A.** Yes, it would.
- Q.** And you would do that presumably because that would be in the patient's interest to do so?
- A.** Yes.
- Q.** Would those tests which you may consider undertaking involve a slit-lamp examination?
- A.** Yes.
- Q.** And a measurement of the intraocular pressures of this patient?
- A.** Yes, I would have considered carrying out intraocular pressure measurement.
- Q.** What about a detailed examination of the ocular structures within the eye itself?
- A.** Yes.
- Q.** Would it be fair to say that the explanation given by Ms Macken for the presenting symptoms was not complete in one sense? A conclusion had been made by Ms Macken that it was a spectacle non-tolerance problem. It would be fair to say that that is perhaps one part of the entire issue, is it not, that there could have been other diagnoses, other conditions which had been causing these symptoms?
- A.** There could well have been other conditions causing the symptoms. What I am sure other optometrists do is we look at the presenting symptoms, presenting information, and see which way it points. In this case everything was pointing to a non-tolerance, and not very much was pointing in the direction of a disease, if anything at all.
- Q.** But you would only know that if you performed the examinations to give you that information.
- A.** No, not necessarily so. Very often patients' experiences and patients' symptoms can help you make a diagnosis. In fact, there is a phrase which I think medical people often use that with a good history and symptoms you

can make 70 per cent of the diagnoses that you need to make. So I do not think it is always necessary to carry out testing. You can make good and accurate diagnosis just based on the patient's symptoms, certainly at a re-check examination when all the tests have been done just a few days ago.

Q. You may need to assist me, as like my learned friend I am not an optometrist, but this patient presents between 12 September and 21 September with what are in effect completely new symptoms. So would it be fair to say that the tests and the records of the examinations performed nine days earlier would have a big question mark over them?

A. No, I do not think that would be fair to say.

Q. Dr Eperjesi, again if you can assist me, the patient presents on 12 September reporting very few symptoms other than perhaps "distance vision poor" according to the record, and it is available I think at page 12 or 13.

A. Yes.

Q. The record of 12 September 2005. The patient we know from her statement says that she had concerns about her driving and her distance vision. She attends before Mr Davies. He undertakes what you call to be a full examination, but would you expect there to be a test of intraocular pressure at this particular presentation?

A. Yes, I would expect there to be intraocular pressure at that examination.

Q. You have concluded still that this would be a full examination?

A. It is not a full examination. The intraocular pressures should have been measured.

Q. The patient presents with no symptoms of pain or actual blurring of vision. To take this scenario one stage further – and I am grateful for your patience – nine days later she is presenting with a complaint of reduced distance vision, headaches, pain in the right eye lasting five minutes. She is also not able to tolerate wearing her glasses for more than two hours over four days. Those are new presentations, are they not, those are new symptoms?

A. They are. Yes.

Q. So there must be a motivation, in this patient's clinical interest, to undertake additional examinations to get to the root cause of where these new symptoms have come from.

A. If you are unsure as to the root cause, then, yes, I would agree, but Ms Macken was sure of the root cause.

Q. Would you have been sure?

A. Would I have been sure? Yes. I am confident I would have done the same, if I had been in Ms Macken's place with this presentation.

Q. Just to take that one stage further, and I am conscious of jumping you to Mr Phillips, but to follow the stages through, you would have performed additional tests on 10 October 2005 I think was your evidence. You would have

performed the same tests and examinations that Mr Phillips said that he performed. I am sorry, it is at page 10.

A. Could you repeat your question, please?

Q. The patient then re-presents on 10 October 2005. She is reporting the same symptoms as before. Your evidence was that you would have undertaken similar examinations to those undertaken by Mr Phillips.

A. Yes.

Q. Why would there be any difference between the two?

A. Oh, I see. You mean why did he carry out slit-lamp and –

Q. I do not understand, Dr Eperjesi, why you are saying you would have performed examinations on 10 October 2005, but your evidence is that you would not have done on 21 September 2005.

A. I do not think I would have looked with a slit lamp on 10 October. It is possible I would have carried out the intraocular pressures having seen that they had not been done on the twelfth. But I do not think I would have looked with a slit lamp with this type of presentation.

Q. To turn very briefly to the slit-lamp examination, Mr Phillips confirmed that there was no trigger for him to look at the angle of the anterior chamber. You have confirmed – if I am wrong, please clarify – that the symptoms presented by this patient could have been indicative of an ocular disease or one of the glaucomas.

A. Which symptoms are we talking about now?

Q. The symptoms of pain, blurring vision and reduced distance vision. The symptoms are within the spectrum of what could be linked to glaucoma.

A. Yes.

Q. Mr Phillips' evidence was that there was no trigger to look at the angle of the anterior chamber. I think Dr Harper explained exactly what that is. My understanding from looking at photographs, but assist me with your expert opinion, is that it is very easy when performing a slit-lamp examination to actually see the anterior angle, it is not something you have to specifically look for.

A. That is correct.

Q. So had you performed a slit-lamp examination, the anterior chamber angle itself would have been fairly clear to you?

A. In this case, I think I would have looked at the cornea, having been aware of the corneal problem with the Fuchs' Dystrophy. You look at the cornea which is an anterior structure to the eye, and then you push forward with the slit lamp to look at the crystalline lens, which is behind the iris. It is possible, the eye and possibly Mr Phillips in moving the slit lamp forward from the cornea to the crystalline lens just missed looking at the anterior chamber angle, because again, according to Mr Phillips' note of the symptoms, there was nothing in what the patient was telling him for him to be alerted to the fact that there may be a problem with the anterior chamber angle, and it is something

that you could just skirt over by moving your focus from the cornea to the crystalline lens.

Q. Would it have been something that you as optometrist would have looked for?

A. I do not think I would have looked for that with the patient's symptoms as recorded by Mr Phillips.

Q. I just want to touch on this issue again of pain as presented by the patient. You in your evidence said that it was not a common complaint, when referring to non-tolerance issues. Would it be more common for pain to be experienced in both eyes if it was a non-tolerance issue, or focused on one particular eye?

A. I think it would be more common for the pain to be in both eyes.

Q. So for it to be focused quite specifically in one eye, as is the evidence of the patient, and the patient records and the investigation of Ms Macken and Mr Phillips, that would actually appear to be something that is quite uncommon.

A. Yes, I would agree with that.

Q. And that would raise, presumably, given the symptoms we have already discussed, the potential other ocular diseases that were potentially indicated by the symptoms presented. You have an uncommon presentation of focused pain in one eye. That would, would it not, raise your index of suspicion that this is something that needs further investigation and exploration?

A. I do not think it would, because pain in one eye can still be part of the overall non-tolerance picture.

Q. But it may be indicative of something much more sinister?

A. It may well be, yes.

Q. I wonder, Dr Eperjesi, referring to Mr Phillips' record on page 10 again – again information has come through in the hearing yesterday which was not available before – did you ask any questions about the nature of the different dates on the record card of him, via the AOP?

A. No, I did not.

Q. Do you have any understanding about what this date, 24 October 2005, could be, or whether the patient re-presented?

A. My understanding is that on 24 October 2005 separate pairs of glasses, distance and vision near glasses, were ordered. That is my only knowledge of that date.

Q. I am sorry, 24 October 2005 was the date that subsequent spectacles were ordered, or would that do you think be the date on which they were collected? It is a very difficult question, I know.

Mr Stern: I am sorry to interrupt, but this is a question that clearly Dr Eperjesi cannot answer. I do not quite understand the nature of the question. Is he

being asked what his interpretation of the note is, or is he being asked what Mr Phillips told him about it?

Mr Alder: I suppose it can be on both grounds. Dr Eperjesi had asked for further information from Mr Phillips via the AOP. I just wondered if there was an interpretation which Dr Eperjesi could put on this additional date.

Mr Swinstead: Let us do it in two stages. Mr Alder, can we do it in this way? Could you ask, please, Dr Eperjesi whether he received any information on this point? That is the first point, and if he did not, he cannot say. The second point, and I think you should put the question carefully, is can he assist the Committee with interpreting that as an expert, not simply in giving his version of it? I think it has to be whether he as an expert looking at that can assist the Committee as to what it is.

Mr Alder: Dr Eperjesi, those are the questions put much more succinctly than I could. Did you seek any further information from Mr Phillips via the Association of Optometrists, about this data recorded on the bottom right-hand corner of the page?

A. No.

Q. Are you able to assist the Committee with any interpretation that you can place on what that date may mean?

Mr Swinstead: With respect, as an expert, not just somebody doing their best.

A. I think on that date separate pairs of glasses were ordered.

Mr Alder: The return to the practice on 10 October 2005 shows one of the most consistent complaints of pain for this particular patient. She returns on 21 September 2005 complaining of pain in the right eye. Mr Phillips reviews the patient, he undertakes some examinations. The patient has confirmed that she has been asked to persevere with the varifocals, but that pain has not at that point been dealt with as a symptom. Would there be anything additionally that you would expect to be performed on the test on 10 October 2005, because of this ongoing issue about the pain and symptoms?

A. It can take many weeks for people to get used to new varifocals. So I believe Mr Phillips thought that this was still a non-tolerance problem, and therefore decided to ask the patient to persist with the glasses. Sorry, I am not sure whether Mr Phillips asked the patient to persist with the varifocals, or whether he made the order there for single-vision or distance pairs. I am not quite sure what happened with Mr Phillips then.

Q. Thank you. You refer to paragraph 29 of the patient's statement. It is at page 8 of your report involving Ms Macken. You refer to point 29 of her statement and you read it through. There is no indication in her statement that that was the actual symptom or comment that she made to either of the optometrists, is there?

A. Could you just repeat that, please?

Q. You have referred quite specifically to point 29.

A. Yes.

Q. You refer to her wearing her old glasses and not experiencing the problems of pain and blurred vision.

A. Yes.

Q. That was not at any point in her statement recorded as being referred to either of the optometrists, was it?

Mr Stern: Sorry, that is not accurate, if I may say so. It is not a question for an expert to answer. It is a question of fact, and if you look at the patient record card of 10 October, it is precisely what is recorded there and what the evidence of Mr Phillips was. "Prefers old RX for near", and you heard evidence from Phillips about that, but I will not go into that now.

Mr Alder: Dr Eperjesi, the purpose of my question in respect of that paragraph 29 is that I am just quite intrigued from a report which is said to be put on an impartial basis; you have only referred to one paragraph in the whole of this patient's evidence. You have not referred, for example, to the complaints she raises as to piercing pain, the use of varifocals for five years, pain and blurred vision. I just wondered why you had referred to that specific selective section from her statement, rather than, I suggest, giving a more balanced view, by taking into account all of the evidence available to you.

A. I did take into account all of the evidence, but I thought that was an interesting point, and I thought that that may be helpful for the Committee, or for this hearing, for me to emphasise that point, that the problems seem not to exist with the old glasses, and that was again highlighting the fact that it could well have been or was very likely to be something to do with the new glasses.

Q. You did not feel it was interesting for the Committee to indicate the patient's evidence that she reported piercing pain to Ms Macken?

A. I was basing my – it is my experience that patients can be –

Q. The question was you did not think it was interesting for the full ambit of the patient's evidence to be put into your report and to form the basis of your conclusions?

A. Aah!

Q. I am sorry I do not mean to amuse you.

A. No, indeed. I am just struggling to answer your question. *[Pause]* I am struggling to answer your question, to be honest. I was trying to base my judgment on the symptoms that had been recorded by the practitioners, because in my experience, patients' recollections can sometimes be inaccurate. So I was trying to base my statement on what had been written down at the time, rather than what the patient had recollected later on. That point I felt was an interesting point, because again, it highlighted my own view on this, that this was very likely to be a non-tolerance case.

Q. Basing your opinion on purely the records, and you have heard the evidence of both Mr Phillips and Ms Macken that they are unable to independently now

recollect the detail of either examination, you also felt it appropriate to via the Association of Optometrists seek clarification from Mr Phillips outside of the record card. You felt that was an appropriate step to take?

A. Yes.

Q. Thank you. Madam, I am grateful. Thank you very much.

Mrs Hallendorff: Thank you. Mr Stern?

Mr Stern: One matter if I may, please.

DR EPERJESI re-examined by MR STERN

Q. You were asked about the slit lamp and the anterior angle, if I put it correctly. Is there any way of knowing what one would have seen, if one had looked with the slit lamp at the anterior angle in or anterior segment, either, on 21 September or 10 October?

A. Is there any way of knowing now what would have been seen then?

Q. Yes.

A. No.

Q. Thank you. Madam, I do not know if you or your colleagues have any questions.

Mrs Hallendorff: Mr Baldwin, do you have any questions?

Mr Baldwin: No.

Mrs Hallendorff: Mr Reily?

Mr Reily: It has been noted that when Patient A saw Mr Davies originally, the intraocular pressures were not taken, and you did mention that you felt that was an omission.

A. Yes.

Q. On the second re-check the intraocular pressures were again not taken. Now bearing in mind that Ms Macken had the record cards of the original examination, do you feel that she should have then taken the intraocular pressures?

A. If she had noticed that the intraocular pressures were not taken, then, yes, I think she should have taken them on the 21st.

Q. She did have the full record card in front of her?

A. Yes.

Q. And do you think that was an omission?

A. If Ms Macken looked at the card and did not notice that the intraocular pressures were missing, then yes, that is an omission. If she looked at the

card and noticed that the intraocular pressures were missing and then did not measure the intraocular pressures herself, yes, that is also an omission.

Q. Thank you.

Mrs Hallendorff: Mrs Huka?

Mrs Huka: Dr Eperjesi, when patients report pain as a symptom, are they in your experience referring to something that hurts? Is that what they tend to mean?

A. Yes.

Q. And is non-tolerance to spectacles supposed to hurt?

A. Sometimes it does, not always, but hurting and pain are often associated with a non-tolerance to new glasses.

Q. Is it usual for non-tolerance to be described in a way that hurts?

A. It is not always described as that, but I do not have any hard-and-fast figures. But the comment, "My new glasses make my eyes hurt", is a common symptom when patients are going through non-tolerance.

Q. Thank you.

Mrs Hallendorff: Mr Swinstead?

Mr Swinstead: No.

Mrs Hallendorff: Thank you very much indeed, Dr Eperjesi.

Mr Stern: Madam that is the case on behalf on the practitioners.

Mrs Hallendorff: Thank you. Mr Alder?

Mr Alder: Madam, I am conscious that we are very much in the Committee's hands at this stage as to the procedure that you will adopt amongst you as to the next stage, and I am conscious that there have been a number of hearings before this Practise Committee which have adopted different procedures. I wonder if it would be appropriate for a brief adjournment of, say, five or 10 minutes in which I can discuss with my learned friend and, indeed, if necessary with the learned Legal Assessor [*Adviser*] whether there is a proposed way forward, or whether it is a matter entirely in the Committee's hands, as that dictates the submissions which both parties will make at this stage.

Mrs Hallendorff: [*Exchange with Mr Swinstead*] My legal adviser tells me that he would be agreeable to that and we will have a break and reconvene at 12.10 pm.

[*Hearing adjourned at 12.06 pm*]

[*Hearing resumed at 12.17pm*]

Ms Hallendorff: Mr Alder, would you like to make your submission?

Mr Alder: Thank you Madam. As you would expect from presenting solicitor at this stage of a hearing, there are very brief submissions for me to make. You and your colleagues have heard, and taken a full note of all of the evidence in respect of the allegations against both registrants. They have been very clearly put to both registrants, charges read out, etc., and you have heard the evidence given by both registrants, but also by the expert opinion of Dr Harper and Dr Eperjesi.

Madam, although in one sense she is not here, the patient's evidence is also central to this particular matter. As I said when seeking the admission of her written statement, it is an affirmed statement, it has a statement of truth at the bottom of it, and is her clear recollection of the symptoms she was suffering from and the symptoms which she recalls were particularly mentioned to both optometrists. Whilst she has not been able to be here - through no fault of her own - that stands as her evidence and is for you to be considered. I suggest that her evidence is, in fact, credible, although it is a matter entirely for you. You have in the hearing bundle of Mr Phillips, her original letter of concern that she addressed to the Council; that is followed up by a more full witness statement. The point, as I understand it, when she completed the witness statement, she was intending, and had hoped to come along to, the hearing, in order to give her very full evidence. Of course, submissions are likely to be made as to individual matters within that statement, or whether they are consistent with the record cards, but I suggest that her very clear recall of the evidence and of the symptoms that she presented with, as well as the subsequent diagnosis of glaucoma, from which she suffered an acute attack, is credible and relevant, important information for you to bear in mind. Of course, her evidence also, in some senses, is supported by the patient records, which record to a greater or lesser extent, those matters which she sets out clearly in her statement: the issue of pain, for example, the headaches. Those things are very clearly put in her witness statement and are matters, I suggest, of central importance to your consideration. It is always difficult when a witness is not here, you cannot see the whites of her eyes, but she as herself a clinician, still works part-time, and therefore that in your mind may allow you to conclude she has a certain knowledge of clinical matters and clinical symptoms, having worked for some time as a radiographer.

What we know from the patient is the symptoms that she was suffering from, the symptoms she presented with and, according to Dr Harper, in fact, whatever version of the symptoms you prefer, whichever symptoms are referred to on the record card, that still leaves a very clear gap in the management of this patient and what tests should have been undertaken in her best interests. We know that she was suffering from headaches, we know that she had focused pain above or in her right eye, we know that she was suffering from blurred vision and reduced distance vision, and as has been accepted by everybody in the hearing before you, including Mr Phillips, Ms Macken, Dr Harper and Dr Eperjesi - all those symptoms are part of the spectrum of symptoms for a number of ocular abnormalities, a number of

ocular diseases including, but not focused on, glaucoma. The symptoms that she presented with on 21 September 2005 are also very similar to the symptoms that she ultimately presented with on 6 November 2005 at Heath Hospital, Cardiff. You could, to an extent, consider her evidence as extrapolating out those symptoms across a period of time.

Dr Harper's expert view is that he has considered the issue of pain and the pain presented by this patient to have been an unusual symptom, in the context of symptoms presented by this patient, which would be indicative of non-tolerance of her spectacles. She presented, of course, with the other symptoms of issues as to her vision, but it is that matter that appears to have formed the focus of the hearing before you. Dr Harper's opinion is that that symptom of pain was unusual, especially focused on one eye, and you will have heard, and I'm sure taken note of, the evidence of Dr Eperjesi, when he confirmed that it was uncommon for there to be specific pain in one eye if it was a non-tolerance issue. It is that issue that drives, in many ways, the Council's case and the Council's concerns, that it was in the patient's interests, given these symptoms, for more examinations to have been undertaken. The Council said that a reasonably competent optometrist would have undertaken the additional tests which are set out in both of the allegations.

I propose not to touch on in any detail the evidence that you heard from Ms Macken or A. you have heard that very clearly, but there is clearly some importance in the particular issue involving Mr Phillips' allegation at 1(i) in respect of the performance of the slit lamp examination that caused some additional discussion between myself, my learned friend and, of course, the Committee. The Council's case is put quite clearly and remains quite clearly put, that there is no suggestion that Mr Phillips is in any way dishonest: his evidence, as you will have heard, is that he can't recall, now, what he did during that examination on 10 October. No criticism of Mr Phillips is put for that, it is now some time ago, but there is an absence of evidence on the record card, from which you, the Committee, can draw the reasonable inference that no slit lamp examination was undertaken. That was put on a number of bases: possibly that Mr Phillips had during the examination transcribed from one record card on to his the notation of Fuchs' Dystrophy. That suggestion was, as you will recall, put to him quite clearly. There's also the suggestion that there was no record of the narrowing of the angle in the anterior chamber, and those lack of notations do provide you with sufficient information, sufficient evidence to draw the reasonable inference that no slit lamp examination was undertaken. You will recall Mr Phillips' clear and very honest evidence, that he has now no independent recollection of that examination, indeed, of this patient's presentation.

The Council's case has been put very clearly: you will have heard the concessions made by both registrants in respect of a number of allegations, for example 2 and 3, and the concession made by Dr Eperjesi in respect of what examinations could have been undertaken for a patient presenting with pain, or presenting with piercing pain. Those are matters for your consideration of the evidence. I suggest that the test that you should apply is

that of the reasonably competent optometrist: what should a reasonably competent optometrist have done in this situation, presented with this patient? The Council suggests that more tests should have been performed by a reasonably competent optometrist, because that is what was dictated by the patient's best clinical interests. A partial explanation was given: an explanation by both registrants that this could have been a spectacle non-tolerance issue. Well, fair enough, but that is not sufficient, in my submission. In the Council's submission, more steps should have been taken before potentially coming to the same explanation, but to get there; you have to tick off the other potential conditions, the other potential ocular abnormalities which could present as a result of these symptoms. That is what, I suggest, a reasonably competent optometrist would and should have done.

You will be asked in due course to consider the facts which form the basis of this allegation. As I pointed out in opening, it is the Council's burden to satisfy you that those facts are proven: you must be assured that the facts are proven. If you find any of those facts proven then, at this stage - and I would ask that this be an appropriate procedure to be adopted and I understand that there is no dispute about this with my learned friend - that you will then be asked to go on and consider whether those facts, if proven, amount to deficient professional performance. It is my suggestion that if you find examinations should have been undertaken when they were not, if an explanation for the symptoms had been given but was not sufficiently in the patient's interests, that the issues of record-keeping for example, which are fundamental to clinical practice, and the interpretation of clinical data is fundamental to that practice, then I suggest that that is to fall below the standard of a reasonably competent optometrist, and allows you to find in respect of both registrants that there has been deficient professional performance.

Madam, that closes my submission. If the Committee wish to adopt a different procedure to the one we have outlined, then I would be grateful for additional opportunity, but I understand that we can proceed on the agreed basis. Thank you, Madam.

Ms Hallendorff: Mr Stern.

Mr Stern: Can I start, obviously with a matter you all know full well, but nevertheless I do want to reiterate: Mr Alder has just mentioned it but I make no apology for reminding him of it, because sometimes when you examine things in minute detail there is a tendency to start to look at whether or not an individual might have done something a bit differently, or might have done something in a slightly different way in hindsight.

The allegation that has been brought by the Council is brought in different sub-headings, as you can see. In relation to Ms Macken, there are a few allegations, as is the position with Mr Phillips, and they are broken down into a number of factual subheads, and you have to look at each of those individually and consider them individually, and consider whether or not any of those allegations are made out. That is to say, you have to be satisfied so that

you are sure in relation to them and looking at the position at the time, not with hindsight.

The first allegation that I want to deal with is head 1. This relates to patient A's visits to the practice on 21 September 2005 to see Ms Macken and on 10 October 2005 to see Mr Phillips. In essence there are two questions in my submission that arise in relation to each of these visits. The first is this: what symptoms did the patient present on that occasion? And the second question, which may follow from that, is what action should each of the practitioners have taken in the circumstances of the particular day, based on those symptoms?

The symptoms you have evidenced from a number of quarters. First of all, you have the letter of 17 January from the patient, you have the statement of the patient dated 15 April 2006, you have the contemporaneous patient record cards, compiled by the practitioners, and to a lesser extent probably, you have the hospital record of what the patient gave as the history on 6 November 2005. The patient's recollection is, in my submission, provably faulty in certain regards, and inconsistent in a number of respects. I don't want to go through all of them, but you can see a number of them.

On 21 September 2005, the date that she deals with at paragraph 29 in the statement, the patient said that she went to the reception desk and asked if she could see someone as she was having problems, so the patient first of all, on 21 September, has come to the practice without an appointment. It appears from the diary as if that's not entirely right, because she came in earlier, having said that there was a fitting problem, and wonders if she could be seen in the afternoon. The statement describes more than one episode of pain before 21 September, whereas the letter of January describes one episode of pain before going. Clearly that's quite an important distinction. She said in her statement that she was not advised to return if there were problems: it's absolutely clear from the patient record cards that she was. The question is not whether she is credible, but the question is whether or not her recollection is reliable, and clearly when a person has been through what obviously must have been a traumatic time, and bearing in mind the fact that patients' recollections are often not as accurate as they might be - as the evidence that you've heard from Dr Eperjesi suggests - then obviously you'll want to look at that carefully.

She did not even describe consistently the period of time that she had been wearing varifocals: it ranges from five years, ten years to three years on the patient record. There is no reference in her statement dealing with 21 September 2005, to any blurring. She describes at paragraph 21 how a lady came out to see her - Ms Macken - 'told her about the piercing pain'. She said, 'She pointed above my right eye'. So, again, there was no reference there about the blurring, but obviously that is a feature which has been recorded by the practitioner.

There is, of course, no cross-examination of the witness: you have not seen her, you have not heard from her, you have not had the opportunity of asking

her questions, and to that extent you would want to think long and hard before accepting what is in her written statement, in the absence of there being any possible questions to be asked of her. Of course, her statement is 15 April 2006, after she had seen the representations of the practitioners, so you will want to consider that in terms of the distance in time as having a considerable health warning upon it.

In relation to the record card for 21 September, you heard from Ms Macken that it is her practice to write the note contemporaneously, that is to say, when the patient is there, and you may think that that makes sense, because it is obviously impossible to do it after the patient has left. She had a gap that afternoon because certain patients didn't attend, and she saw the patient first of all outside the consulting room and then inside. The patient reported – and it is important to look at the symptoms in relation to each of the occasions, because, with respect to Mr Alder, he has on occasions blurred two of those two presenting symptoms, because there is no reference to blurring in relation to Mr Phillips. So, one has to look at the symptoms carefully and analyse them separately, and look at them individually.

In relation to this patient, the patient came and described blurring, or a difficulty with distant vision. Nothing unusual, you may think, there, with a patient who had a brand new pair of varifocals and had had them for about four days, had tried them, apparently had only been able to wear them for about two hours a day of those four days. So immediately you may think that the practitioner is thinking that there is something wrong with the spectacles, that the patient is unable to wear them for more than two hours a day. Also, the patient has described headaches and a pain in the right eye for five minutes. Now, that would be an extraordinary thing to write down if the patient had come in and said, I generally get piercing pain, or I have had piercing pain, because, clearly, that would be something that would have been written down. You know it is not accepted by Ms Macken or indeed Mr Phillips, that there was an expression by the patient of piercing or any other type of pain or intense pain. As I say, the statement was taken after the patient had seen the representations. That is clear, you may think, from the patient record, and both of these practitioners would have no reason not to put down the extent of the pain if, indeed, that was the position.

There is a limited amount of support, apart from the obvious fact that you have not heard from the patient and therefore not heard her being cross-examined, and from the patient record, at what I believe in your bundle is page 23 - you can look at it at a later stage if you want to - but it's the first page of 6 November 2005. You will see there that in setting out the symptoms it says, 'Patient gets pain, then vision clears', and then below that it says, 'This episode, vision not clearing, last night pain ??+++'. So the patient was making a distinction on 6 November, with 'pain ??+++', and in the past with just having pain. So there is no record there of having had piercing pain, or having had intense pain, or describing the pain in the past as being pain +, or some degree beyond just ordinary pain. So there is, in my submission, some degree of support, and there is no evidence to support what the patient has described as the expression of piercing or intense pain at all. In addition

to which, you know that the patient was reporting – and this is important – on 21 September 2005, as she was on 10 October, that the problem that she was having was when she was wearing the new spectacles. So the patient was associating the decrease in vision, the headaches and the single episode of pain with the spectacles.

I accept that that is not conclusive, but what a practitioner does – and forgive me if I am saying things to at least two practitioners, but there are other people here who are professionals and know what the position is - when a person comes to see you and describes various points, obviously you assess those, but you do not actually say, right, you are coming to the doctor with a problem with your foot and the doctor says, “right, we’ve got to send you off for an ECG, we’ve got to send you off for a stress test and we’ve got to send you off for all these other things”. A doctor does not wish a patient to go through a whole series of unnecessary tests, but exercises his or her clinical judgment at the time, and in doing so, assesses what the problem is, comes to a conclusion, a clinical judgment, doing the best they can at the time, and that’s exactly what these practitioners did. It is not right to say, well, maybe you could have done that, and that’s only because the patient ended up, unfortunately, with this particular type of rare glaucoma. But for that, obviously, we would not be here. Nobody would be analysing that and saying, your re-check was not sufficient. So, to some extent we are in the world of looking backwards, which I advise against.

There is support for what the practitioners say on 21 September and 10 October about this issue, or the problem being limited to the spectacles, because at paragraph 29, which in my submission is an important paragraph in the patient’s statement, she said, ‘I started wearing the new pair of glasses, but they had the same effect as before’. We are not sure which pair of glasses she is talking about there, but, “Over a period of about three weeks, I had been wearing my old glasses, and I did not experience the problems of pain and blurred vision as I did when wearing the new glasses”. She has taken the time, trouble and effort to put that into the statement in April 2006, so you may think that it is very likely that she would have made that very point to the practitioners, and that is significant. In addition to that, Ms Macken knew on 21 September that the prescription that had been given by Mr Davies on 12 September was increased or changed quite considerably – one and a half in the right eye and one in the left eye.

I want to just remind you of Dr Harper’s evidence, because I submit that this is the central part of the first allegation. He was asked,

“So far as you are concerned, you have never had a patient complain of pain of any description, as a result of having new spectacles.

Yes” - that’s my instructing solicitor’s note, transcribed helpfully, for me.

“No reasonable optician could have come to the conclusion they did.

I do not believe that pain, it cannot be attributed to non-tolerance of spectacles” - I am picking some of his answers.

“Other people have different experiences?

Yes.”

So that was, according to the notes we have, and certainly, my recollection because I put it to Dr Harper that his evidence really comes to this: because of the pain that the patient was saying was a symptom, because in his experience pain is not a symptom of non-tolerance of spectacles, therefore he would not have accepted that as an explanation, therefore he would have carried out more tests. That is his evidence.

But that is not the experience of the two practitioners you have heard from, plus the practitioner Dr Eperjesi. So, one looks, then, at the level of experiences and type of experiences that these people have had. If it is right that both Ms Macken, Mr Phillips and Mr Eperjesi have had those experiences, one assumes that they are not *not* telling the truth about that, and there's no suggestion they are not, so they have had those experiences – reasonable practitioners have had the experiences of having patients come in with varifocals or new spectacles, and having a problem with tolerance. In fact, you even heard that in relation to one particular make, Dr Eperjesi's practice has stopped having them at all because of the non-tolerance difficulty, which includes the question of pain. So you have to look, and obviously evaluate the evidence of Dr Harper, and the evidence of the other individuals, and look at them carefully.

So far as Dr Harper is concerned, you have what is described as his *curriculum vitae*, but, I do not wish to be unkind but you may think it is a little more like an introduction to 'Question Time' because it does not actually have the dates and goes through it in the sort of way that might be helpful, so I had to ask him a number of questions about it. Significantly, not clear you may think from this *curriculum vitae* is his level of experience which is precisely the issue that you need to know in order to be able to assess how he is able to say that pain is not a symptom of non-tolerance. It transpires that in fact, between 1987 and 1994, he had seven years' part-time experience as a High Street optometrist. I accept he has been an optometrist, and that is obviously right, he has been a hospital optometrist, where of course a whole series of tests are already laid out for the practitioner, and he has not, therefore, dealt with people coming in for re-checks, problems with spectacles, in the same way that clearly the three practitioners you have heard from on behalf of the practitioners have experienced.

What he said in his report is a bit concerning, because what he has said is that – I'm looking at page 56 in relation to Ms Macken, at the foot of the page, the third line up – 'However, the symptom of pain is not one that would be expected to arise normally from a spectacle intolerance problem'. Clearly, if one says 'not normally' then it does imply that it is possible to have that symptom, but it transpired that his evidence was he had never experienced such a symptom, and therefore, that is something that one would have thought should have been made absolutely clear in his report, but he has not done that. He has suggested that it does not arise 'normally', but that's not his experience; his experience is that it has never arisen, and so that is, in my submission, quite an important and inaccurate, quite frankly, assertion.

So how is one able to assess a High Street practitioner's position? Is he able to do that properly – in my submission, his evidence should not be preferred to those of the practitioners you've heard from, and indeed, Mr Eperjesi, who has had 16 years and continues to work in a High Street practice.

What is it that the Council have to show here in relation to the first allegation? The Council, in my submission, have to show that no reasonable optometrist would have acted in the way that these practitioners did. You can describe it in some other way, but essentially what it comes down to is that a reasonable practitioner would have acted in the way that they did. You have heard from Ms Macken and, indeed, from Mr Phillips, both of whom you may think are perfectly reasonable practitioners if not above reasonable practitioners, and you have heard from Dr Eperjesi who said, not only as an expert but, "I personally would have done the same". An above average practitioner.

So, in my submission, that evidence cannot be made out by Dr Harper's evidence, because the issue was agreed by Dr Harper and by Dr Eperjesi that if the practitioner concluded reasonably that the symptoms related to non-tolerance then both the examination and the notes were adequate. Dr Harper was asked, "as far as the notes are concerned, if it is right that a reasonable practitioner believed this to be spectacle intolerance, and therefore it was a re-check, the notes are adequate", and he said the tests and the notes are reasonable. I appreciate he went back a little bit in relation to Ms Macken on the intra-ocular pressure point – and I'll come back to that if I may, the point that was raised by Mr Reily, with Dr Eperjesi.

This is a patient who comes in, unable to wear her spectacles for more than two hours, she has new varifocals with substantial change, she has had a sight test nine days earlier, and with a single episode of pain, and all practitioners must make an assessment of the most likely cause. Of course, any of us can go to a doctor with a headache and it can turn out to be a brain tumour, but the fact is, when we go to the doctor we are not instantly investigated for everything that might be incredibly serious, we are investigated for very normal types of problems, and only if the problem becomes worse or goes on for longer do we then go back to the doctor and the doctor says "well, perhaps we had better go and get you tested now on this, that or the other, if it does not get better". So, it is unreasonable to apply hindsight and suggest that a High Street optician looking at the most common cause, which is the pain associated with non-tolerance, should then carry out a whole raft of tests because it may in the end turn out to be glaucoma. One has to go on the majority of symptoms and the majority of presentations.

It is frankly not realistic to suggest that any health practitioner should operate in a different way. Why would a practitioner consider an extremely rare type of glaucoma, which affects 0.6 per cent of the population, to be present here? The symptoms, as was raised by Mrs Huka in the report of Dr Harper, are set out at page 56 if anyone wants to follow. It is pain, headache, blurred vision, halos around lights, watering, aversion to light, nauseous, vomiting, red eye, cloudy cornea, thick semi-dilated pupil, markedly raised inter-ocular pressure. That is from Dr Harper's report. Well, obviously, pain and headache come

within it, but that does not mean to say that, “ah, glaucoma” – that is not, in my submission, the way that health practitioners work. So one has to look at what a perfectly reasonable practitioner would do, and you have Dr Eperjesi’s evidence, which I commend to you as being the most reliable on that.

In relation to Ms Macken, it is right to say that if she came to the conclusion that she did, then the tests that she carried out were appropriate, bearing in mind the symptoms. I want to just deal, as I said I would, with the points raised about whether or not intra-ocular pressure should have been carried out by her on 21 September, bearing in mind they were not done on 12 September – raised by Dr Harper, I think, although not in his report, and raised, perfectly properly, by Mr Reily in relation to the expert. The position is this, which is why I started in the way that I did: it is not appropriate, in my submission, to alter the allegations if something should have been done, when one examines the minutiae. That was not the allegation set out by the Council. The allegation is that the presenting symptoms were such that these tests should have been done. That was the way the case was opened, and it has not been closed any differently. But as I understand it, what Dr Harper is saying, what Mr Reily was asking me about – as I say, perfectly fairly – is, the pressures were not carried out on 12 September, irrespective of the symptoms, because no pressures had been taken at this sight test on 12 September, therefore they should have been done on 21 September, because the practitioner should have noticed that that had been omitted. I hope I have understood the point that was raised.

In my submission, it would be wrong, if you come to the conclusion that what the practitioner did was right or might have been right, which is the basis of the test, in relation to the actions that she took, to look back and say, “well, in fact, by virtue of penning through every detail of the case over the last two days, we have found another allegation, and we would quite like to mark that”. I hope you do not mind me putting it like that, but that is the way it might appear. So that, in my submission, would be unfair.

10 October 2005 - Mr Phillips - the patient returns, and again, one has to look at the symptoms separately. The patient came back and reported that she had had three episodes of pain, *after reading* with these new spectacles, and that she had had frontal headaches, again, with the new spectacles. Now, obviously the writing might leave a little to be desired, to the right of it, but ‘Prefers old prescription for near’, and Mr Phillips told you about that, that he had understood that, and crucially understood that, in my submission, to mean that the problem again was with the new spectacles, and that when she wore the old spectacles she did not have that problem. That is precisely what she has put in her statement, that she did not have a problem with her old spectacles, so if she has made that remark it seems very likely that she would have said that. There is no reference to blurred vision or, indeed, that what had happened was only in the evening, so again, it is important to look at the differing versions individually.

The allegation against Mr Phillips is first of all that he failed to perform a slit lamp examination – you have heard the evidence on that, and quite frankly, if

you need me to say any more about that, perhaps it would be worthless, because in my submission, that is an extraordinary stance taken by the Council, not based on evidence but based on speculation, and indeed, it is really unattractive to seek to dance around the maypole by saying, "I'm not really saying that Mr Phillips is not telling the truth". Well, that's precisely what the allegation is, because he gave evidence that what he had done was – and you can see where it is written in the examination section - that he had carried out a slit lamp examination, and that was his evidence and he did not just write it out by copying Mr Davies' record card. One needs to exercise a degree of realism and a degree of professional maturity to back down sometimes when the allegation is clearly not made out.

In relation to the tests that were carried out, the near visual acuity was performed according to Mr Philips, you have his evidence on that, there is no record of it. A reasonably competent optometrist, Dr Eperjesi says, would have made a note of the near visual acuity. He has not done so, but he does not consider that to be – if I can put it in this term - a very grave error. So that being the position, he performed an examination of near visual acuity. That head is not made out in my submission, and there is no reason to suggest that Mr Phillips departed from his experience of 40 years from doing it; he told you that he did it. The intra-ocular pressures were well within the normal range, in fact they are 13, and so they are on the low side. He did carry out an assessment of the motor ocular balance, the muscle balance test, and the results were normal, he looked at the internal structure of the eye using a slit lamp. He concluded that the problem was non-tolerance of new spectacles, and Dr Eperjesi's evidence was that that was perfectly reasonable and, again, he would have done the same. He prescribed an increase for reading prescription, from +2.25 to 3.25 and also two pairs of spectacles, one for near vision and one for distance vision. In fact, the prescription that he prescribed was almost back to the original prescription that the patient had had before.

The criticisms by Dr Harper are essentially two-fold: that he did not perform an external eye examination – well, he says he did, and he found nothing abnormal – and the anterior segment assessment. He did carry out a slit lamp examination, but did not look at the anterior segment because he came to the conclusion that it was not necessary, for the reasons that you have heard. So he did obtain an adequate explanation for the presenting symptoms, and he concluded that that is what they were, non-tolerance of spectacles, and he did complete an adequate record of the examination in the terms set out by Dr Harper, which is essentially that because further tests should have been carried out, those tests were not in the record card, and therefore the record card is not adequate. That is basically what Dr Harper is saying.

Can I deal with allegation 2 and 3. Again, I am not entirely clear that they are very obvious as to what it is that is being alleged. In relation to Ms Macken, it is said that in the representations to Council of 7 March, she inaccurately interpreted patient A's hospital medical notes, with regard to the date of onset of her symptoms. There was some concern about what that meant, and those instructing me had a conversation, that I am not going to go into, of course,

with Mr Alder, but the result is a letter from him dated 15 May, which I will read just a short part of:

“As we discussed, it is my view that it is clear from the face of each particular, in conjunction with Robert Harper’s opinion, the issue which the Council has concerns about, particulars 2 and 3, confirm errors on behalf of both registrants in the interpretation of clinical data. It follows that reasonably competent optometrists would have interpreted clinical information accurately.”

So it is the interpretation of clinical data that, as we understood the position, was the case that we had to meet here at this hearing. If the interpretation of clinical data means 1/7, which is presumably what it means, and 3/52 – 3/52 is not mentioned in the letter of Ms Macken, nor in Mr Davie’, therefore they cannot be a failure of interpretation, because it does not actually feature in the letters. If there is a failure in inaccurately interpreting the hospital medical record in terms of 1/7, then yes, they have inaccurately interpreted it, made an error, and it’s an error that Dr Harper himself made on at least two occasions in his report, so you may think that that is so minor and so *de minimis*, that it really ought not to feature in a hearing of this sort, in any shape or form.

There is no allegation beyond that, and I want to make it clear that that is what is asserted in relation to head two.

Head three: again, it’s not entirely clear what the point is, but it says in Ms Macken’s representation she referred to patient A’s previous records, indicating minor corneal changes, which is inaccurate. And if one looks at the letter that was sent by Ms Macken – it’s at page 51 in your bundle, Ms Macken’s bundle – it is the fourth paragraph down on page 51:

“I reviewed Mr Davies’ notes which detailed early lens changes, minor corneal changes (Fuchs’ Dystrophy), etc.”

There is absolutely nothing inaccurate about that in my submission at all, because Mr Davies’ notes do in fact say all of that. She has set out the detail, early lens changes that is the nuclear sclerosis, the minor corneal changes - which is Fuchs’ Dystrophy - and the CD ratios of 0.2, all of which are on Mr Davies’ notes for 12 September. There is nothing inaccurate about that, and the allegation that she referred to patient A’s previous records indicating minor corneal changes, which is inaccurate, is, quite frankly, not one that is clear to me.

In relation to Mr Phillips – his letter can be found at page 52, the third paragraph down - I presume this is the part that is being referred to:

“I reviewed the patient’s notes. Aware she had been seen previously 12 and 21 by my colleagues. Their notes detailed early lens changes, minor corneal changes and CD ratios of discs appearing shallow in both eyes. Records show the disc and macula to be healthy”,

and then he concludes that the notes were accurate and still relevant. So again, Mr Phillips' representation that he referred to patient A's previous records indicating minor changes which are inaccurate, are not inaccurate, and for the first time Dr Harper, I think, made the point - I do not believe it is in his report, but obviously you have the report, so you can see whether it is a point or not. In any event, they have sent a letter in, and when it comes to the Optical Council they have the patient record cards, the hospital record cards and so anything that is there can be seen and there is nothing inaccurate about what they had submitted. So in my submission, in relation to all of these heads, as the allegations are made and as the allegations are met, there is no evidence that these practitioners are guilty in relation to each of those heads.

In relation to the question of deficient professional performance, if there is, for example, an inadequate record of the near visual acuity, and that is not recorded, or indeed, the IOP, in my submission, neither of those could amount to deficient professional performance in the context of this case.

Those are my submissions, Madam.

Ms Hallendorff: Thank you

Mr Swinstead: Mr Alder, before I advise the panel, can I just confirm that this is what I propose to advise them. In both the allegations where at 1) it is said either that Ms Macken or Mr Phillips did not do various things, you are alleging they are failures effectively, failing to do something, rather than just simply did not, i.e. that there is a culpability. Otherwise they would just be factual, somebody didn't do something so they must be, must they not?

Mr Alder: Sir, they are, in one respect, with respect, not designed in that sense, but they are to be based upon the factual admissions, so whether these tests were performed or not, the issue as to whether they should have been performed is a matter for the Committee to consider as to whether those factual matters which are admitted or proven amount to deficient professional conduct.

Mr Swinstead: Yes, but they are failures to perform, and they import a culpability. If they don't import a culpability, for instance, if Ms Macken, for example, didn't perform a slit lamp examination and the Committee finds on all the evidence heard that it was not necessary for her to do it, so, yes, she did not perform the slit lamp, but there's no culpability because if the Committee were to find, for example, that it was reasonable for her to come to the conclusion she did that it was merely a problem with the new glasses, then, whilst technically they could find she didn't perform it, there must, must there not, be imported that it's failure, it's a culpable failure? She failed to perform a slit lamp examination when she should have done. Is that not right?

Mr Alder: Sir, the culpability itself, to my mind, becomes relevant at the stage as to whether deficient professional performance is considered and made out. I do struggle slightly. The initial allegation before the procedural hearing itself did include the terms 'failed to'. There was quite some discussion with the

defence lawyer at the time. I am conscious that that defence lawyer is not here available today, but the allegation itself was changed in order to avoid that scenario that there could be a series of factual admissions, or a series of factual allegations that are proven, but that the issue as to culpability itself is one which is in a sense wrapped up as to deficient professional performance.

Mr Swinstead: Sorry, with respect, I don't think the Committee could consider deficient professional performance unless the failings were culpable, if I can put it that way, and therefore, there has to be culpability, it has to be a failure.

Mr Alder: Sir, indeed, the failure in that sense perhaps is assisted by use of the words "and by reason of the facts set out above". It is the Council's position that these tests and these examinations, explanations, record cards, were below the standard expected of a reasonably competent optometrist, that there is a failure to have performed, for example, the slit lamp examination, but the point at which the culpability itself becomes relevant for the purposes of the charge itself is at that point as to consideration of deficient professional performance.

Mr Swinstead: I am sorry to have raised this at this rather late stage, but I didn't realise there was an issue. Mr Stern?

Mr Stern: I have always assumed that it was a failing, and it makes no sense to present it in any other way. I don't quite understand the difficulty that Mr Alder is having with this. The position is this that the allegations are that by reason of the facts above, you are guilty of deficient professional performance. Well, you can't be guilty of deficient professional performance if you have no duty to carry out a slit lamp. Why not include, as I said before, a field test? It doesn't make any sense. The point is, and the Council's case is, that there was a failure to perform a slit lamp examination, for the reasons you've just given, and I won't repeat, because of pain, or whatever, that is the Council's case. Whether or not a practitioner accepts that that was not done or it was done, ultimately the Committee will have to make the same decision, which is whether or not it was a failing, and no practitioner should admit to not doing something that it was not necessary to do.

Mr Swinstead: That's rather my understanding. Mr Alder, I have to say this, and I'm relying to a certain extent on the previous case I did with this Committee, where the allegations were similar, that the registrant did not do certain things, and it was understood on both sides that those were effective failure. It was a similar allegation as set out to this.

Mr Alder: Sir, they are, in the Council's case, failures. I suppose it is the point at which that is considered as part of the Committee's consideration. The case has always been on the basis that these tests should have been performed and that it was the reasonably competent optometrist's duty to have done so.

Mr Swinstead: Can I just say that I propose to advise the Committee that "did not, in allegation 1, import culpability", that is a failure. Depending, obviously, how the Committee then find, they will go on to decide whether or not, if they find

failings, those amount to deficient professional performance. That's what I propose to do. Do you urge me not to do that?

Mr Alder: Sir, you have heard my submissions. To say more would be to repeat the point that charges are as put. There is clear culpability, in the Council's case there has been a failure on each of these grounds. The charge is put as on a factual basis, that there was no performance of a slit lamp examination. At what point their culpability is considered is in my submission a matter for the Committee. It's certainly how previous cases before the Fitness to Practise Committee have proceeded, but I'm conscious that the stage the Committee has now reached will tie those processes up into the same process.

Mr Swinstead: Can I say that I propose to advise the Committee that "imported into" did not amount to a failure i.e. that is culpability. For example to perform a slit lamp examination - that is, that Ms Macken should have done it, and she didn't.

Madam, my advice is therefore as follows. My duty is to tender advice to you as to the law, rather to direct you as to the law. The position is that you are the judges of both the law and the facts. You have now reached the stage of firstly determining whether the facts alleged, which have not been admitted – in fact, none of them have – in allegations against both registrants, have been proved by the evidence that you've heard, and you do that under the provisions of Rule 50 of your Rules. The burden of proof with regard to any disputed fact rests throughout upon the Council; there is no burden upon the registrants at any stage in these proceedings to prove anything.

As to the standard of proof, the Council must satisfy you so that you are sure, before you find any fact proved against either registrant. You must consider each particular of each allegation separately, and you must consider each case separately. Your approach must be with regard to each individual factual allegation against either registrant: have the Council proved the fact to my satisfaction, so that I am sure it is proved? Anything less and the registrant is entitled to a finding of 'not proved'. As I have just indicated, the words 'did not' are used, and I import, certainly, into that word, a failure. And where a failure is alleged, in that a registrant did not do something, then that is an allegation that he or she *did not do* and *should have done*, whatever is alleged, and that he or she was under a duty to act in the particular way described, and did not do so. Where such an allegation is made, it must be culpable. What makes it culpable, you must be satisfied before you make a finding of culpability that at the material time the registrant was under an obligation to take a particular course of action, according to the standards of good practice which were in existence at the time, and that he or she did not take that course of action.

You have heard expert evidence from Dr Harper and Dr Eperjesi. An expert witness is permitted to give his opinion on the issues before you, but you are not bound by an expert's opinion. It is not the proper approach to expert evidence that you should simply accept an expert's evidence, in the absence of reasons for rejecting it.

If you find the evidence and opinion of assistance, you are entitled to rely upon it in coming to your conclusions. If you do not find it of assistance, then you are entitled to reject it, and to place no reliance upon it. What you make of expert evidence is entirely a matter for you. As for your approach to individual pieces of evidence, you are entitled to draw inferences, but you must not speculate. If you feel that it is proper, you can draw an inference provided there is an evidential basis for it. On the other hand, it would be wrong to speculate.

I remind you particularly that as far as Patient A's statement was concerned, this was read to you because she was not medically fit enough to attend and give oral evidence before you. When considering her evidence, you must remember that she was not cross-examined on it by Mr Stern, and you were not able to ask questions, and you must bear this in mind when considering her evidence and what weight you should give to it.

Madam, I then turn to the second part of your task at this stage, which is to consider whether on the basis of the particulars of the allegations in each case, you find whether or not the registrant is guilty of deficient professional performance. It is a matter of judgment for you to consider, whether in each case the registrant is guilty of deficient professional performance, based upon the matters which you found proved.

If I could just deal with, in broad terms, the test that you may well consider that you should apply, and it has been set out, I think, by both Counsel. It can be put this way: that the allegation that in each case fell below the standard of a reasonably competent optometrist, or that the registrant acted as no reasonably competent optometrist would act. Madam, I would suggest to you that effectively those two things mean the same thing, and broadly, that is the test that you should apply, as I say, exercising your judgment.

Madam, that's my advice. Would either wish me to say anything further, or to add anything to what I have said?

[No further advice required]

Ms Hallendorff: Thank you very much. I suggest, then, that we break. We will work on this over a working lunch, I suggest, and we will call you when we are ready. I cannot give you a time on it at this stage. Thank you very much.

[Hearing adjourned at 13.25pm]

[Hearing resumed at 15.32pm]

Ms Hallendorff: Thank you. Dealing with Ms Macken first, the Committee accepted the advice of the legal adviser, and has considered allegations 1(i) through to 1(vii), in terms of culpable failures.

The Committee found particulars 1(ii) of the allegation proven.

The Committee found particulars 1(i), 1(iii), 1(iv), 1(v), 1(vi) 1(vii) and particulars 2 and 3 of the allegation not proven.

The Committee gives the following reasons for its decision: with regards to particulars 1(i), (iii), (iv), (v), (vi) and (vii) the Committee considered Ms Macken treated patient A reasonably on the basis of the presenting symptoms. With regard to particular 2 the Committee noted that Dr Harper, the expert witness called on behalf of the Council made the same error, in that he interpreted the symbol 1/7 as designating one week rather than one day, and Dr Eperjesi indicated in evidence that he was aware that this mistake was easily made. On the basis of the evidence, the Committee was not satisfied that this particular point was proved. With regard to particular 3 the Committee did not consider the evidence adduced on this particular issue supported the allegation.

The Committee found particular 1(ii) proven on the basis, not of patient A's presenting symptoms but on the fact that the record of the examination on 12 September 2005 did not show that this test had been undertaken, and on this basis the Committee was satisfied that Ms Macken should have carried out this test on 21 September 2005. Because of this finding on particular 1(ii), the Committee finds Ms Macken guilty of deficient professional performance.

The Committee is inclined to the view that the basis on which it has found Ms Macken guilty of deficient professional performance would not support a finding that her fitness to practise is impaired.

Turning to Mr Phillips, the Committee accepted the advice of the legal adviser, and has considered allegations 1(i) to 1(iv) in terms of culpable failures.

The Committee found particulars 1(iv) of the allegation proven.

The Committee found particulars 1(i), 1(ii), 1(iii) and particulars 2 and 3 of the allegation not proven.

The Committee gives the following reasons for its decision: the Committee found Mr Phillips to be a credible witness, and accepted that he did perform a slit lamp examination. In consequence, particular 1(i) was found not proven. With regard to particular 1(ii) the Committee considered Mr Philips treated patient A reasonably on the basis of presenting symptoms. With regard to 1(iii) Mr Phillips said in evidence that he performed a near visual acuities test and the Committee accepted his evidence. With regard to particular 2 the Committee noted that Dr Harper, the expert called on behalf of the Council, made the same error, in that he interpreted the symbol 1/7 as designating one week, rather than one day and Dr Eperjesi indicated in evidence that he was aware that this mistake was easily made. On the basis of the evidence the Committee was not satisfied that this particular was proved. With regard to particular 3 the Committee did not consider the evidence adduced on this particular issue supported the allegation. With regard to 1(iv) the Committee found that there had been a culpable failure to record the result of the near visual acuities test and further, the Committee found that there was only a

partial recording of the slit lamp examination. By reason of this finding on particular 1(iv) the Committee finds Mr Phillips guilty of deficient professional performance.

The Committee is inclined to the view that the basis upon which it has found Mr Phillips guilty of deficient professional performance would not support a finding that his fitness to practise is impaired.

I turn to Mr Swinstead.

Mr Swinstead: The Committee has given, as it were, an indication with regard to a preliminary view on impairment, but of course that would not prevent you at this stage making whatever submission you would wish on the issue of impairment, and obviously Mr Stern would respond. And I think it right to remind in particular Mr Stern, that under Rule 13F(5), if a Fitness to Practise Committee find that the registered optometrist's fitness to practise is not impaired, they may nevertheless give the registrant a warning regarding his future conduct and performance. Therefore, whatever view the Committee were to come to, you may wish to make submissions on that point at this time. I hope that is clear, and of assistance to both parties.

Ms Hallendorff: Mr Alder, do you wish to comment?

Mr Alder: Madam, I am just seeking very quickly instructions directly from the Council. I propose to make no submissions at this time, and I am grateful to you for your indication. The Council has acted in this case in good faith all the way through, but I am very clear of the provisional view taken by the Committee and propose to make no submission at any stage on impairment of fitness to practise.

Ms Hallendorff: Mr Stern.

Mr Stern: Madam, I don't propose to say any more about impairment, bearing in mind there is no submission to meet, and you have already given your preliminary indication. I don't want to spend some time on the question of warning, but if you would like me to at least deal with it, I am grateful for the learned Legal Adviser's comments.

Can I just very briefly draw your attention to the documents in your bundle that you have not as yet looked at. As I say, I don't know what your view will be. Obviously so far as Mr Phillips is concerned, he is retired and therefore bearing in mind the finding, a warning is really not something that you would think would be appropriate in relation to him for that, because the purpose of warning is obviously to assist the practitioner in the future, and he is not going to practise in the future. Can I just express what I am sure would be Mr Phillips' gratitude for your comments in relation to head 1(i) and head 1(iii), so I am sure that he will be grateful for those comments. You appreciate that he is not here, and he obviously, I'm sure, will greet those words with some degree of gratitude.

So far as Ms Macken is concerned, you will see that there are a considerable number of references, and you can see that she is essentially a thoroughly good and competent professional. I can take you through them, but if you would prefer to read them for yourselves, that is, of course, a matter for you. Would you prefer me to go through them, or read them?

Ms Hallendorff: Mr Baldwin?

Mr Baldwin: Just read them.

Ms Hallendorff: I think we can just read them. [Pause] Thank you, Mr Stern.

Mr Swinstead: I should also add, you do have a letter in relation to Mr Phillips in that bundle as well, just the one letter. Perhaps you'll read that as well, in due course.

Can I just deal with your finding in relation to Ms Macken. The allegation that you found, you have made clear, was not on the basis of the Council's case, but on a different basis that emerged from the evidence. Indeed, if one looks at Mr Harper's report, he did not indicate that pressures should be taken or needed to be taken, save for the symptoms – and I'm looking at page 55 and 56, I don't ask you to look at it – so when one's putting the allegation in its context, it's not on the basis of the allegation as put by the Council or indeed Dr Harper's report, although I appreciate what he said in evidence went outside that. This comes about, effectively, as a result of Mr Davies not carrying out the intra-ocular pressures on 12 September, and he was before the investigating Committee and the investigating Committee rejected any case in relation to him. So, to some extent, she is now falling foul of a matter that was originally rejected, as it were, insofar as any matter looked at by Mr Davies – they had the record card – and he was not placed before the Committee, so she is to some extent vicariously liable for his omission, if I can put it in that way. In the context of the re-check you have found her conduct to be acceptable, and but for the fact that it was omitted on 12 September, as I understand the reasoning that you have given, she would not have had to carry out the intra-ocular pressures. So she is effectively mopping up the omission by Mr Davies.

Looking at the reports and character testimonials that you have here, as I say, I would invite you to read them in due course, I am not going to go through them all, but drawing the threads together, it's quite clear that far and wide she is seen as a diligent, hardworking, honest, caring professional, and aware of her own limits and competence, and acting in the best interests of the patient. That, I think, characterises what those remarks make. So in my submission, this is not one of those cases where a warning would be appropriate or, indeed, necessary, bearing in mind, as I say, I'm not even sure that there's evidence that she noted that the intra-ocular pressures had not been carried out on 12 September.

In relation to Mr Phillips, as I say, that is not that he did not carry out the test itself, you have been good enough to make that clear, but that he failed to

note it, and I think as Dr Eperjesi said, you could infer it from the note, albeit it would have been more helpful if it had been clearer. Well, that is one of those – if I may say so – rather small points. I don't mean to minimise it, but you understand the distinction meeting various grades, as it were, of things that come before you, this is at the very lowest end, as, indeed, my submission is, is Ms Macken's, in the circumstances of this particular case. So in my submission, fitness to practise is not impaired – you have already given a preliminary indication – and as I say, there is nothing further that I need to make submissions about it, and indeed, a warning is not necessary or called for in this particular case. Those are my submissions.

Ms Hallendorff: Thank you.

Mr Alder: Madam, if I may just interject at this point to confirm a point in respect of the case involving Mr Davies, just to be absolutely clear that there is no risk of you being misled as to that case. As you will appreciate, the Investigation Committee has a number of options available to it when considering a case referred back to it. The Investigation Committee is difficult because these submissions obviously would, in the ordinary course of events, remain a matter not on the public record. However, the Investigation Committee in respect to the conduct of Mr Davies did not decide to do nothing, it decided not to refer this case to the Fitness to Practise Committee, but it did decide that it was appropriate in that case to insist upon Mr Davies attending a performance review, to ensure the competence of his practice. So it is not the situation – you may find it unattractive anyway, for Mr Davies to be in some way blamed, being unable to have the opportunity to present himself here before you - but it is important that you are clear that the Investigation Committee did not conclude that there was no culpability on his part at all, but have concluded that it was appropriate to refer him for a performance review. I just think it's important to raise that point before you, to ensure absolute clarity.

Ms Hallendorff: Thank you.

Mr Stern: I'm sorry, I didn't know that, I did not have that information, nor did my instructing solicitor, but I understand a performance review is voluntary, that is what I am told, but I don't know any more than that about what a performance review is, I'm afraid.

Ms Hallendorff: Thank you.

Mr Swinstead: Madam, I would just formally give you advice that your task at this stage would be to consider whether the allegation in the case of each registrant's fitness to practise is impaired, by reason of your finding of deficient professional performance in each case, but you've heard that no submissions have in fact been made by Mr Alder, and you've heard submissions from Mr Stern on the issue of warning. Obviously the matter involves an exercise of your judgment. Were you to find that in each case the practitioner's fitness to practise was not impaired, I remind you that under Rule 13F(5), and I read,

“If the Fitness to Practise Committee find that the registered optometrist’s fitness to practise is not impaired, they may nevertheless give the registrant a warning regarding his future conduct or performance”.

Madam that is the only piece of advice I give you, unless either party would wish me to say anything further, or wish to query anything I have said.

[No further advice required]

Ms Hallendorff: In that case, may we retire, and we will call you back in due course.

[Hearing adjourned at 15.53pm]

[Hearing resumed at 16.44pm]

Ms Hallendorff: To conclude our determination, in the case of Ms Macken, the Committee found that the fitness of Ms Macken to practise as an optometrist is not impaired, and announces its reasons as follows:

The Committee, in finding Ms Macken’s fitness to practise not impaired, took account of the fact that on the one matter on which it found her professional performance to be deficient, this concerned a failure to measure intra-ocular pressures on a basis not originally put before it in evidence by the Council, but that the evidence was that Mr Davies, who carried out the examination on Patient A on 12 September 2005, failed to carry out a measurement of intra-ocular pressures, or if he did carry out such measurement, failed to record the results. When Ms Macken saw Patient A on 21 September 2005, she failed to take account of the fact that there was no record of the measurement of intra-ocular pressures on the record card of the examination of 12 September 2005, and consequently, she should have carried out such a measurement.

In reaching its decision, the Committee took account of the fact that Mr Alder, on behalf of the Council, did not make any submissions to the effect that Ms Macken’s fitness to practise was impaired. Having reached this decision, the Committee went on to consider whether it would be appropriate to issue a warning. In reaching its decision on this matter, the Committee took account of Mr Stern’s submission and the testimonials and CET records put before it on Ms Macken’s behalf.

The Committee has decided that Ms Macken will have learnt a salutary lesson from her appearance before this Committee, and she will have learnt lessons which she will carry forward in her practise. Consequently, the Committee does not consider it necessary to issue a warning.

Thank you, Ms Macken.

Turning to Mr Phillips, the Committee found that the fitness of Mr Phillips to practise as an optometrist is not impaired, and announced its reasons as follows:

The Committee, in considering that Mr Phillips' fitness to practise is not impaired, took account of the fact that with regard to the one matter in which his professional performance was found to be deficient this concerned a failure to complete an adequate record of the examination in two respects, namely a failure to record the near visual acuities, and a partial recording of the slit lamp examination. It noted these were not matters specifically alleged by the Council in the presentation of its case. Whilst the Committee considered this was a falling short of the standards of a reasonably competent optometrist, these failings would not lead to a finding of impairment. The Committee further noted that Mr Alder, on behalf of the Council, did not make any submissions on the issue of impairment.

The Committee considered whether it should issue a warning in Mr Phillips' case, but decided that a warning was not appropriate. In reaching its decision, the Committee noted that Mr Phillips had indicated that he has now fully retired.

Thank you.

[The Hearing ended at 16.47pm]