



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

**GENERAL OPTICAL COUNCIL**

**F(22)10**

**AND**

**JOHN ASUEN (01-21597)**

**DETERMINATION OF A SUBSTANTIVE HEARING  
8-12 AUGUST 2022  
9-13 JANUARY 2023**

<b>Committee Members:</b>	Graham White (Chair/Lay) Mark McLaren (Lay) Ubaidul Hoque (Lay) Amit Jinabhai (Optometrist) Catherine Collin (Optometrist)
<b>Legal adviser:</b>	Ian Ashford-Thom
<b>GOC Presenting Officer:</b>	Sam Smart
<b>Registrant present/represented:</b>	Yes and represented
<b>Registrant representative:</b>	Trevor Archer (Counsel) Victoria Koramoah (AOP) 8-12 Aug 2022 Katie Holland (AOP) 9-13 Jan 2023
<b>Hearings Officer:</b>	Terence Yates
<b>Facts found proved:</b>	1(a), 1(b) and 1(c)i and ii (left eye only)
<b>Facts not found proved:</b>	None
<b>Misconduct:</b>	Found
<b>Impairment:</b>	Not impaired
<b>Warning:</b>	12 months'



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## ALLEGATION

*The Council alleges that you, Mr John Asuen (01-21597), a registered Optometrist:*

1. *On or around 4 May 2019 you attended to Patient A, and you:*
  - a. *Failed to perform a dilated fundus examination of Patient A's left eye and/or right eye;*
  - b. *Failed to detect signs of a retinal detachment in Patient A's left eye and/or right eye;*
  - c. *Failed to maintain adequate patient records, in that you:*
    - (i) *Did not record an accurate patient history for Patient A;*
    - (ii) *Did not record whether Patient A's floaters were new and/or had changed;*
    - (iii) *Did not record which visual field assessment test was used for Patient A*

*AND that by reason of the matters alleged above your fitness to practise is impaired by reason of misconduct.*

## Preliminary Application

1. At the outset of the hearing, Mr Smart on behalf of the Council applied to amend the above allegation.
2. The proposed amendment was in the following terms:
  1. *On or around 4 May 2019 you attended to Patient A, and you:*
    - a. *Failed to perform a dilated fundus examination of Patient A's left eye and/or right eye;*
    - b. *Failed to detect signs of a retinal detachment in Patient A's left eye and/or right eye;*
    - c. *Failed to take and/or record an adequate history for Patient A, namely:*
      - (i) *Failed to adequately explore and/or record Patient A's description of seeing her cheek in her left eye and/or right eye;*
      - (ii) *Failed to establish and/or record the duration and nature of the dots in Patient A's left eye and/or right eye;*

*AND that by reason of the matters alleged above your fitness to practise is impaired by reason of misconduct.*

3. The word “adequately” in paragraph 1 c (i) of the proposed draft originally read as “further”, but Mr Smart, in the course of his submissions and in the light of discussion with the Committee, agreed that changing this to “adequately” would improve its clarity.
4. Mr Smart referred the Committee to the General Optical Council (Fitness to Practise) Rules Order of Council 2013 (“the Rules”) at Rules 46(20) which is in the following terms:

*(20) Where it appears to the Fitness to Practise Committee at any time during the hearing, either upon the application of a party or of its own volition, that—*

*(a) the particulars of the allegation or the grounds upon which it is based and which have been notified under rule 28, should be amended; and*

*(b) the amendment can be made without injustice, it may, after hearing the parties and consulting with the legal adviser, amend those particulars or those grounds in appropriate terms.*

5. Mr Smart submitted that the proposed amendment better describes the alleged mischief and more specifically defines the issue to be decided. He further submitted that it narrows the issue from a generalist description of a record-keeping error to a description of specific failure to take/record Patient A’s relevant medical history. The amendment describes the allegation in line with the failing identified in the expert report of Dr Kwartz and does not add anything new to the case against the Registrant. Accordingly, he submitted that there was no prejudice to either party and that the amendment can be made without injustice. Mr Smart also submitted that maintaining accurate records included taking an accurate patient history. The proposed amendment clarified this point.
6. Mr Archer on behalf of the Registrant opposed the application. He submitted that, far from being clearer and more specific, the proposed amendment does not fairly define the case which the Registrant has to meet. It fails, in the proposed 1 c (i), to define the nature and extent of the alleged duty to explore and/or record Patient A’s description. It also introduces in 1 c (i) and (ii) a reference to the right eye, which Mr Archer submitted, is not supported by any of the evidence. By the same token, the proposed 1 c (ii) fails to specify what exactly is meant by the “duration” and “nature” of the dots described by Patient A. Mr Archer therefore submitted that the proposed amendment would cause injustice to the Registrant.
7. The Committee accepted the advice of the Legal Adviser, which included reference to Rule 46(20).
8. The Committee retired in order to give the application detailed consideration.

9. The Committee considered carefully whether the amendment could be made without injustice. The Committee accepted that this included potential injustice to both parties, although it bore in mind that fairness to the Registrant was a prime consideration. The Committee was of the view that particular 1 c, as it initially stood presented the allegations in a manner which was focused on recordkeeping. The Committee decided that the amended particular more clearly defines the enquiries, which it is alleged the Registrant should have carried out, and which should in turn have been recorded.
10. The Committee also concluded that the proposed amendment more accurately reflects the subject matter of the expert reports, which have already been presented to the parties. Accordingly, there was nothing in the proposed amendment which could take the parties by surprise.
11. With regard to the reference to the right eye, this corresponded to the existing allegations in particular 1 a and b. If, as was submitted by Mr Archer, the allegation in respect of the right eye was not the subject of any supporting evidence, then it would inevitably fall away.
12. The Committee was satisfied that the wording of the proposed amendment was sufficiently specific, clear and easy to understand. It did not accept Mr Archer's submission that the wording lacked clarity.
13. The Committee was also satisfied that the proposed amendment could be made without unfairness or prejudice to either party.
14. Accordingly, the Committee determined that the amendment could be made without injustice and allowed the application.

### **Background to allegations**

15. On 4 May 2019, Patient A attended for an eye examination at Specsavers in [Redacted], where she was seen by the Registrant. The reason for her visit was that she could see her left cheek in her left eye, but not in the right eye, and was also seeing dots in her left eye. She reported this, and a longstanding history of floaters, to the Registrant.
16. A number of tests were carried out by the Registrant, but this did not include a dilated fundus examination, a test which should be carried out where a patient is suspected of having symptoms of a detached retina. The Registrant does not accept that Patient A's account of her symptoms called for such an examination. Patient A's left eye was to that extent not fully examined and she was not alerted to any issues. She left the Specsavers practice that day, believing that whatever it was would heal itself.

17. Some weeks passed and Patient A's symptoms did not improve. She did some internet research and booked herself for another appointment. On this occasion, on 9 July 2019, she attended [Practice B], where she was seen by a different optometrist. She repeated the concerns about her eye, that she was seeing her cheek and the spots she was seeing. She was examined; a detached retina was identified in her left eye and she was immediately referred to Moorfields Eye Hospital. She attended Moorfields Eye Hospital that day where she was assessed and told that she had a detached retina and that she needed to attend for surgery the following day, which she did.
18. It is alleged that the Registrant failed to detect the signs of a detached retina. It is also alleged that he failed to perform a dilated fundus examination, and failed to take an adequate history, or adequately investigate or record, Patient A's symptoms.

### **The hearing**

19. The Committee heard live evidence called on behalf of the Council from Patient A, together with expert evidence from Dr Anna Kwartz, a registered Optometrist. On behalf of the Registrant, the Committee heard live expert evidence from Dr Lyndon Taylor, a registered Optometrist, who had prepared a report dated 7 July 2022. The Registrant also gave evidence to the Committee.
20. The Committee was also provided with bundles of documentary evidence on behalf of the parties. The documents in the Council's bundle included a report, dated 16 February 2022, by Dr Kwartz, Patient A's witness statement, dated 15 December 2021, Patient A's comments on the Registrant's case, relevant medical records relating to Patient A, and records of Patient A's complaints in relation to her eye examination by the Registrant.
21. The Registrant's bundle included the Registrant's witness statement, dated 2 August 2022, Mr Taylor's report, dated 7 July 2022, a Clinical Opinion Report, dated 21 July 2021, prepared by Ms Denise Voon, a registered Optometrist, for the Council's Case Examiners, and training records relating to the Registrant.
22. During the hearing, Dr Kwartz and Mr Taylor prepared a Joint Expert Report, which was dated 8 August 2022, although it was only put before the Committee on 10 August 2022 (day 3 of the hearing).
23. The first part of the virtual hearing of this case, when the live witness evidence was heard, took place between 8 – 12 August 2022. The hearing was then adjourned part-heard to 9 – 13 January 2023. On 9 January, the Committee heard closing submissions in relation to the facts alleged in the allegation from the parties' representatives, both of whom helpfully provided the Committee with written copies of those submissions.
24. For the Council, Mr Smart submitted that there was a substantial measure of agreement between Dr Kwartz and Mr Taylor, particularly in the light of their Joint Report. He submitted that Patient A's evidence, supported by the documentary records, demonstrates that, at her eye examination by the Registrant on 4 May 2019, she reported symptoms to him which should have prompted him to investigate and record whether or not she had suffered a retinal detachment.

25. Mr Archer, on behalf of the Registrant, submitted that Patient A's recollection of what happened at an eye test that took place more than 3 years ago is unlikely to be reliable. He suggested that her recollection may have been influenced by facts of which she was subsequently made aware. He further submitted that nothing took place at the eye examination to alert the Registrant to symptoms suggestive of a detached retina; it was accepted that Patient A reported floaters in her vision, but these are quite normal for a person of her age, and the Registrant elicited that her history of floaters was longstanding and not, therefore, indicative of a retinal detachment. It was also accepted that Patient A reported to the Registrant her concern that she could see her left cheek, a symptom which could be such an indicator. It was submitted, however, that it was not unreasonable for the Registrant to conclude that this was attributable to the need to carry out an adjustment to Patient A's varifocal spectacles. Mr Archer emphasised that the legal test, which the Committee must apply, is whether the Council has proved that the Registrant's decisions and judgments were outside the range that any reasonably competent registered Optometrist could have made. Provided they were not outside that range, there would be no 'failure' (as alleged in the allegation) on the part of the Registrant to fulfil his professional duty. Mr Archer referred to the expert reports obtained by the Council from Ms Voon and from Dr Kwartz, and pointed out that they had reached very different conclusions. That, Mr Archer submitted, provided a good example of how the range of professional opinion in a case may legitimately differ. Mr Archer submitted that Ms Voon's opinion, that the Registrant's actions were reasonable, provided strong support for the proposition that his actions fell within the bounds of a reasonably competent registered Optometrist.
26. The Committee heard and accepted advice from the Legal Adviser, which included advice that the burden of proof throughout lies on the Council to prove, on the balance of probabilities, each of the facts alleged in the allegation. The Legal Adviser also endorsed Mr Archer's submissions as to the correct legal test to be applied.

### **The decision on the facts**

#### **Particular 1 c. (i) and (ii)**

27. In reaching its decision on the facts, the Committee decided that it was preferable to consider first the allegations set out in particular 1 c. (i) and (ii), as its findings in relation to those allegations were likely to be relevant to its consideration of the allegations in particular 1 a. and b.
28. Particular 1 c. is in the following terms:

*"1. On or around 4 May 2019 you attended to Patient A, and you:*

*...*

*c. Failed to take and/or record an adequate history for Patient A, namely:*

*(i) Failed to adequately explore and/or record Patient A's description of seeing her cheek in her left eye and/or right eye;*

*(ii) Failed to establish and/or record the duration and nature of the dots in Patient A's left eye and/or right eye;"*

29. Patient A in her evidence confirmed that she attended a sight test appointment with the Registrant at Specsavers on 4 May 2019. She stated that the reason for the appointment:

*"... was that I was thinking I could see my cheek from my left eye and on occasions, being able to see dots in my left eye. ... I reported the same to Mr Asuen."*

30. Patient A recalls having a scan, which was shown to her, and recalls the Registrant saying, *"all looked normal, or words to that effect."* She stated that the Registrant told her, *"if I had any problems, to go back."* If there were no such problems, she was informed that her next examination should be in 24 months.

31. Patient A stated that following her eye appointment with the Registrant on 4 May 2019, her symptoms did not improve. Her left eye felt weak and she continued seeing her cheek and dots. She looked on the internet and saw retinal detachment could be the cause. This prompted her to make an appointment with [Practice B] on 9 July 2019. At this appointment, investigations were carried out which confirmed the diagnosis of a detached retina. Patient A was immediately referred to Moorfields Eye Hospital, where she underwent surgery to her left eye.

32. On 16 July 2019, when she was still recovering from her surgery, Patient A sent a complaint to Specsavers, which included the following:

*"Hi, I booked an appointment at this branch because of previous good experience. However on this occasion I was seriously let down. My complaint was floaters, black dots and being able to see something at the bottom of my eye (shadow). The optician John Asuen ... didn't have any concerns and put me on a 2 year recall."*

33. Patient A also made a complaint on 10 March 2021 to the General Optical Council (GOC), which included the following:

*"I attended Specsavers [Redacted] branch May 2019 because I was seeing black dots on a regular basis, sometimes like a shower. This was very different from the usual floaters I had experienced in the other eye. I also told the optician that I could see my cheek in the bottom of my eye. This was before I researched my condition on line [SIC]. I should have used the word 'shadow' or 'curtain'. He told me there was nothing to worry about and showed me the routine scan they took at the start of the appointment."*

34. A letter from solicitors representing the Registrant set out verbatim his response to Patient A's complaint, which included:



*“I did not fail to perform dilated fundus on patient A’s left eye and/or right eye. I can confirm that, I attended to patient A at Specsavers Opticians, [Redacted] on 4 May 2019. However, contrary to the allegation that, “I failed to perform fundus examination of patient A”, my decision on whether or not dilated fundus examination was required, was based on the information that patient A provided, in addition to the clinical record of patient A at the time. My decision was based on sound professional opinion, which was that, a dilated fundus examination was not required for a complaint of longstanding floaters. Therefore, the decision not to perform dilated fundus examination on patient A on 4 May 2019, was purely based on sound clinical justification.*

*“On examination of patient A’s left eye and/or right eye on 4 May 2019, there was no clinical signs of retinal detachment in patient A’s left eye and/or right. Therefore, on the strength of the actions taken in relation to patient A’s left eye and/or right eye, I can confirm that, I did not fail to detect signs of a retinal detachment on 4 May 2019. Please see patient A’s clinical record of 4 May 2019.”*

35. The above letter also referred to the expert report of Ms Voon which, it was contended, provided support for the Registrant’s rebuttal of the allegation.
36. On 15 September 2021, in response to the letter from the Registrant’s solicitors, which had been sent to her for her comments, Patient A sent an email dated 15 September 2021 to the GOC in which she responded

*“One or two of the comments are not accurate.*

*“I went to the opticians because I saw dots and had a shadow or curtain in the lower part of my eye. (I described this as being able to see my cheek as I didn’t know the correct terminology). I had not had the dots before or the shadow before, that’s why I was worried.*

*“Previously at Specsavers I saw a different optician who confirmed with me that I had floaters which are the wispy things that move across my vision. These are very different from the shower of dots I experienced when I visited JA. I have since found out that opticians call dots floaters as well, but I mentioned to JA that I had dots, and they were nothing like the traditional floaters I had experienced before. At my previous appointments at Specsavers, I would not have described the wispy floaters as dots.*

...

*“The professional opinion to the GOC said I did not present with increased floaters which is not true. I presented with dots (different type of floaters) and they would come in a shower and nothing like the usual floaters.”*

37. In her supplementary witness statement dated 27 February 2022, Patient A confirmed that the contents of her email dated 15 September 2021 were true and accurate.

38. The Registrant's case was as follows. He stated that Patient A told him that she had made the appointment because her last one had been about 2 years ago and she was due another. He accepted that she had told him about some occasional floaters which were longstanding. *"She told me the floaters were like dots and has had them before the last test in 2017."* Accordingly, the Registrant considered he had, not unreasonably, understood her to be describing her longstanding floaters when she told him about the dots.

39. With regard to Patient A seeing her left cheek, the Registrant's account in his witness statement was as follows:

*"She told me she wore varifocal glasses and that she could see her left cheek with her glasses on. I have come across this type of complaint many times with varifocal wearers. It is not an uncommon complaint. In my over thirty years of practice as an Optometrist, I have seen all sorts of patients and heard different kinds of complaints from varifocal wears so this alone did not cause me significant cause for concern."*

40. The Registrant stated that he addressed Patient A's reported problem of seeing her cheek, which he had concluded was attributable to the need for her spectacles to be adjusted, in the following way:

*"Thereafter, I took Patient A to the reception, handed her over to an optical assistant in the form of a three-way hand over and requested that they do a post screen visual fields test and also, explained that the patient varifocal be adjusted and fitted properly to avoid her seeing her cheek with her varifocal."*

*"The Optical Assistant would have come back to me if there had been any issue with the adjustment as if they have any issues with doing their job they will notify me and they know I am happy to help."*

41. The Committee noted that Patient A's evidence was that she had no recollection of any adjustment to her spectacles being carried out.

42. The Registrant's record of the examination included the following, within the box designated "Reason for Visit:"

*"RFV- Respond to recall SEE DOTS OCC.IN THE LE AND HX OF LONGSTANDING Floaters PX ALSO THINK SHE CAN SEE HER CHEEK WITH THE LE, BUT NOT THE RE No diplopia / Flashes / Headaches DV OK NV OK No other problem reported"*

43. The Committee was assisted by the Joint Expert Report. The section relating to particular 1 c. is as follows:

***"c. Failed to take and/or record an adequate history for Patient A, namely: (i) Failed to further explore and/or record Patient A's description of seeing her cheek in her left eye and/or right eye;***

*Both experts agree that there is insufficient information in the record regarding Patient A's symptom of seeing her cheek with the left, such as its duration and relationship to spectacle wear. Further, the outcome of the optical assistant's adjustment of the spectacles is not documented eg regarding whether or not the symptom resolved following the adjustment.*

*(ii) Failed to establish and/or record the duration and nature of the dots in Patient A's left eye and/or right eye;*

*We both accept that it is documented that Patient A suffered from longstanding floaters. The record does not present sufficient detail to be certain as to whether the dots represented an alteration in the longstanding floaters (ie a clinically significant symptom for retinal detachment) or were an unchanged manifestation of her chronic floaters."*

44. The Committee also took into account the following passages from Dr Kwartz's report:

***"6. You are required to provide your expert opinion on the following matters:***

***6.1. In your expert opinion, did the registrant carry out all appropriate tests/examinations, for example a dilated fundus examination, during the sight test with Patient A? Please explain why or why not.***

*6.1.1. Patient A's symptom that she could see her cheek with her left eye (but not her right) is an unusual description and not a typical patient complaint. ... As it is improbable that in a normal situation, a patient can see their cheek on one side only (or indeed at all), I consider that a reasonably competent optometrist would have asked further follow-up questions in order to elucidate the exact nature of the problem to establish if Patient A was suffering from a visual complaint that was suggestive of an eye disease that would require further investigation. It is a frequent occurrence that patients use unusual or representational terminology to describe their symptoms and it is the clinician's responsibility to interpret their visual experience(s).*

...

*6.1.3. From Patient A's email of 15 September 2021, she avers that her observation of being able to see her cheek was her description of a shadow or curtain over the vision in the lower part of her eye. Further credence should be added to her version of events, as the record from [Practice B] (9 July 2019) states that Patient A complained of a shadow with her left eye for the last 3 - 4 months, and the hospital notes of 10 July 2019 state that she had been aware of a shadow [in her vision] since May. Patient A also states in her email that the "shower of dots" she reported to Mr Asuen were different from the floaters she had experienced previously. If both of these pieces of evidence are accepted and it is considered that Patient A would have given these responses in response to John Asuen's questioning, then I consider that he should have related them to possible retinal detachment.*

45. The Committee considered that Dr Kwartz's evidence set out above, which was supported by her oral evidence under oath, was cogent and persuasive. Accordingly, the Committee accepted her evidence.

46. The Committee accepted that Dr Kwartz and Mr Taylor were to a substantial extent in agreement in their evidence, particularly once their Joint Report had been produced. To the extent, however that their opinions differed, the Committee preferred the evidence of Dr Kwartz.

47. The Committee also took into account the following passage from Mr Smart's questions of Dr Kwartz:

*“MR. SMART: Finally -- last question -- the fundamental issue in this case, is it not, is the symptoms that Patient A complained of at that eye exam, is that correct?”*

*A. Correct.*

*Q. Because depending on what was said at that eye examination, what tests were and were not appropriate all flows from that conversation, is that correct?”*

*A. Agreed. So when you take a history from a patient you are using that as a foundation to plan your onward examination. So if it was the case that Patient A complained of an increase in floaters or a shower of floaters then that was definitely a reason to proceed with dilated fundus examination.*

*Q. Sorry, I know I said last question but I have one more. Is it just the presence of increased floaters or is it the comorbidity of increase in floaters and a shadow on the eye or the being able to see the cheek?”*

*A. Correct. It is actually both because they are both almost working together to build up this index of suspicion. If the problem of seeing the cheek did persist after spectacle removal or spectacle adjustment then absolutely that is also strongly suggestive of a developing pathology.*

*MR. SMART: Thank you, Dr. Kwartz. I do not have any more questions for you.”*

48. Further, in this context the Committee had regard to a question by a registrant member of the Committee to Mr Taylor, together with his answer:

*“Q.... I think really my question is that normally if a patient has said “I have got long-standing floaters” you say that it is not expected that the optometrist goes into lots and lots of detail about the nature of the floaters if they have responded “long-standing floaters”. But my question is that if a patient is reporting long-standing floaters and been able to see their cheek in the same eye would you expect further questioning?”*

*A. Well, I know Dr. Kwartz felt very much that the two things coincided together. In one sense I agree with her and there were two things in the left eye, which is always a bit iffy.”*

49. The Committee recognised that the recollections of both Patient A and the Registrant of the examination on 4 May 2019 are bound to be less than wholly accurate and complete after the passage of time. However, the Committee was satisfied that, where their recollections conflicted, Patient A’s account was generally preferred. Patient A gave her evidence in a credible, balanced way, acknowledging when her recollection was lacking. The Registrant’s evidence, on the other hand, was at times surprisingly detailed, given that the appointment was so long ago and that it was, on his own evidence, an unremarkable, routine appointment. An example of this surprisingly detailed recollection is the passage quoted above regarding the words used by Patient A when describing the dots to him.

50. The Committee was also satisfied that the Registrant's account of what Patient A told him is inconsistent with his own contemporaneous record. "SEE DOTS OCC IN THE LE AND HX [i.e. "history"] OF LONGSTANDING Floaters," can only be construed as a record of Patient A reporting two, distinct symptoms to the Registrant. The Committee did not accept that this record could be interpreted as meaning that Patient A was describing her longstanding floaters as dots. The record of Patient A seeing dots occasionally in the left eye is separated from the record of the history of longstanding floaters by the word "and", which indicates clearly and straightforwardly that they are records of reports by Patient A of separate symptoms.
51. The Registrant's contemporaneous record also shows that Patient A reported a third symptom, namely that she thought she could see her cheek with her left eye, but not the right eye. The Registrant's case is that he formed the opinion that the problem was attributable to the need for Patient A's spectacles to be properly adjusted. He contends that this opinion was not unreasonable as it fell within the range of opinions which could be reached by a reasonably competent registered Optometrist.
52. The Committee was satisfied, on the balance of probabilities, in the light of the above evidence of Dr Kwartz and paragraph 1 c. (i) of the Joint Expert Report, that the Registrant was clearly under a duty to take and/or record an adequate history for Patient A, namely by adequately exploring and/or recording her description of seeing her cheek in her left eye. The Committee was also satisfied, on the balance of probabilities, that he had failed to discharge this duty.
53. In considering the allegation set out in particular 1 c. (ii), namely that the Registrant failed to take and/or record an adequate history for Patient A, namely failed to establish and/or record the duration and nature of the dots in Patient A's left eye, the Committee took into account the evidence set out above, including paragraph 1 b. (ii) of the Joint Expert Report, together with the following passage from Dr Kwartz's report:
- 6.1.2. The record states that Patient A could see dots occasionally with her left eye. I do not consider that this symptom has been recorded in sufficient detail, in that its nature and duration have not been documented. Fundamentally, an optometrist is concerned with establishing if their patient is experiencing an increase in floaters, which could be suggestive of posterior vitreous detachment or retinal detachment. In my opinion, the level of detail in which the symptom has been recorded does not allow this analysis to be made.*
54. In the light of the above evidence, the Committee was satisfied, on the balance of probabilities, that the Registrant was under a duty to take and/or record an adequate history for Patient A, namely failed to establish and record the duration and nature of the dots in Patient A's left eye. It is clear from the evidence of Patient A, together with the paucity and inadequacy of his reference to this aspect in his contemporaneous record, that the Registrant failed to discharge this duty.
55. In reaching its conclusions in relation to these particulars, the Committee respectfully agreed with Dr Kwartz's opinion set out above, to the effect that where a patient reports more than one potentially suspicious symptom and there is a comorbidity of reported symptoms, they almost work together to build up the "index of suspicion". Mr Taylor, in his response to the Committee member's question quoted above, referred to Dr Kwartz's opinion and expressed a similar view: "In one sense I agree with her and there were two things in the left eye, which is always a bit iffy."

56. In the light of its conclusions, the Committee found particulars 1 c.(i) and (ii) proved, subject to one proviso.
57. Each of the above particulars refers to Patient A's "left eye and/or right eye." It is common ground, however, and the Committee entirely accepts that the allegations in this case, and the evidence in support, relate solely to Patient A's left eye. The particulars are therefore found proved solely in so far as they refer to the left eye.

**Particular 1a.**

*"On or around 4 May 2019 you attended to Patient A, and you:*

*a. Failed to perform a dilated fundus examination of Patient A's left eye and/or right eye;*

58. As the Committee had anticipated, its findings of fact in relation to particulars 1 c. (i) and (ii) are highly relevant in relation to this allegation.
59. The Committee referred to the relevant section in the Joint Expert Report:

*"1. On or around 4 May 2019 you attended to Patient A, and you: a. Failed to perform a dilated fundus examination of Patient A's left eye and/or right eye;*

*Both experts agree that if the panel decides that the patient history/discussion would have led an RCO to believe she was at risk of retinal detachment eg a change in floaters and/or the visualisation of her cheek persisted when her spectacles were removed, then the registrant should have performed dilated examination.*

*Both experts agree that if Patient A had stated that the dots she saw with her left eye were exactly the same as her longstanding floaters and if she said that the symptom where she could see her cheek resolved when the spectacles were adjusted, then it was reasonable for JA not to proceed with dilation, as there were no indications ie symptoms suggestive of detachment."*

60. The Committee also referred to the evidence of Dr Kwartz in her report:
61. *"6.1.4. If paragraph 6.1.3 is accepted, I aver that John Asuen should have conformed to the requirements described in paragraph A203 of the prevailing College of Page 5 211 Optometrists' Guidance for Professional Practice which deals with the management of patients with flashes of light and floaters. It states, "If you suspect a retinal break or tear you should, as a minimum:*
- a take a detailed history and symptoms, looking for particular risk factors*
- b examine the anterior vitreous to look for pigment cells*
- c perform a dilated fundal examination, using an indirect viewing technique, and*
- d give appropriate advice to the patient, which you back up with written information."*
- From this list, John Asuen did not undertake items b, c and d and I consider that these would be the actions of a reasonably competent optometrist."*

62. The Committee accepted Dr Kwartz's evidence.
63. The Committee was satisfied, on the balance of probabilities, that the Registrant should from the outset of the appointment have suspected a retinal tear when, according to his contemporaneous record, Patient A complained of seeing dots and of seeing her left cheek. These suspicions would have been heightened had the Registrant undertaken the investigations and other steps referred to in particular 1 c. (i) and (ii), as the Committee has found he was duty bound to do. The Committee was satisfied that he had failed to discharge this duty.
64. The Committee was also satisfied that there was no tenable evidence to indicate that Patient A's symptoms in respect of seeing dots and seeing her cheek resolved when her spectacles were removed, or when they were adjusted. The Registrant, surprisingly, did not himself remove Patient A's spectacles, nor did he adjust them himself. His evidence was that he left this task to an assistant after the examination had ended. He also stated that he would have expected the assistant to revert to him had the adjustment been unsuccessful. However, in the Committee's judgment, it would be far too tenuous to infer from this that any adjustment was successful in alleviating the symptoms. In any event, it is clear from Patient A's evidence, which the Committee accepted, that her symptoms did not resolve but in fact persisted for the following two months until her condition was diagnosed and treated.
65. The Committee therefore found particular 1a. proved, on the balance of probabilities.
66. Again, for the reasons already given, the reference in this particular to the right eye is irrelevant and unsupported. Accordingly, the particular is found proved solely in so far as it refers to the left eye.

67. **Particular 1b.**

*"1. On or around 4 May 2019 you attended to Patient A, and you:*

*...*

*b. Failed to detect signs of a retinal detachment in Patient A's left eye and/or right eye;"*

68. The Committee took into account the relevant passage in the Joint Expert Report:

*"b. Failed to detect signs of a retinal detachment in Patient A's left eye and/or right eye;*

*There is uncertainty as to whether there was actually a frank retinal detachment present on the index date. However, in this circumstance, we both agree that fundus examination following pupil dilation, together with a check for Shafer's sign would have increased the likelihood of detecting peripheral retinal pathology."*

69. The Committee also accepted the evidence of Dr Kwartz in her report:

***"6.2. In your expert opinion, was a detached retina present at the time of the sight test with the registrant or what was the likelihood of the detached retina being present at the time of the sight test with the registrant? Please explain.***

6.2.1. *Retrospectively, it is not possible to categorically state whether Patient A was suffering from a retinal detachment on 4 May 2019. I note that Patient A's condition was not diagnosed until 9 July 2019 and the macula was still attached, so the detachment had not progressed extensively, if it was present at the index examination. Typically, superior retinal detachments can progress quite quickly (unlike their inferior counterparts) and it would be unusual for one to persist for 2 months.*

6.2.2. *However, Patient A's symptom of being able to see her left cheek is strongly suggestive of an alteration in the inferior visual field and consistent with pathology of the superior retina. Patient A also avers that she had noticed a "shower of dots" which is characteristic of floaters. The two symptoms are strongly suggestive of retinal detachment.*

6.2.3. *Further, the examination record of 10 July 2019 from Moorfields Eye Hospital documents that the retina was "slightly stiffened" which is consistent with chronicity of the detachment, which could be consistent with the 2-month interval between onset of symptoms and diagnosis.*

6.2.4. *In my opinion, there was sufficient evidence on 4 May 2019 to consider that Patient A had symptoms suggestive of retinal detachment that were worthy of further investigation. In terms of determining the likelihood of a retinal detachment definitely being present, I suggest that an ophthalmologist with a vitreo-retinal sub-speciality is consulted for an opinion."*

70. The Committee noted the evidence that it is not possible retrospectively to state with certainty that Patient A had a retinal detachment on 4 May 2019, given that her retinal detachment was only diagnosed on 9 July 2019.
71. However, in the Committee's judgment, this consideration is irrelevant to its consideration of this particular. The particular does not allege that the Registrant failed to detect a retinal detachment in Patient A's left eye. The particular alleges that he failed to detect signs of a retinal detachment.
72. In this case, the Committee was satisfied, on the balance of probabilities, that the Registrant should have detected the signs of retinal detachment by properly investigating the symptoms reported to him by Patient A, and by carrying out a dilated fundus examination of Patient A's left eye. The Committee was therefore satisfied that the Registrant failed to discharge this duty.
73. The Committee therefore found particular 1 b. proved, on the balance of probabilities.
74. Again, for the reasons already given, the reference in this particular to the right eye is irrelevant and unsupported. Accordingly, the particular is found proved solely in so far as it refers to the left eye.

### **Misconduct**

75. Having found the facts alleged in the allegations proved, the Committee moved on to consider whether those facts amount to misconduct.

76. The Committee invited submissions from the parties.
77. For the Council, Mr Smart referred to a number of authorities in which the meaning of “misconduct” in this context has been considered. He submitted that the authorities demonstrated that, for misconduct to be established, it must be shown that the Registrant’s acts or omissions fell seriously short of the standards expected of a registered Optometrist. Mr Smart submitted that this case falls within that category.
78. Mr Smart referred the Committee to a number of provisions in the GOC’s 2016 Standards of Practice for Optometrists and Dispensing Opticians and in the College of Optometrists’ Guidance, which he submitted were not followed by the Registrant in relation to his examination and treatment of Patient A. He specifically referred to section A203 of the College of Optometrists’ Guidance.
79. Mr Archer, on behalf of the Registrant, also emphasised that it is not just any professional misconduct which will qualify. The professional misconduct must be serious. He further submitted that the conduct must be judged by the seriousness of the error, rather than the seriousness of its consequences for the patient, and that a series of incidents of misconduct that are not serious should not be aggregated to reach a finding of serious misconduct together. Mr Archer pointed out that the Registrant has enjoyed a lengthy career with an unblemished record, having practised for more than 30 years. He submitted that the question for the Committee was whether the initial failure on the Registrant’s part to recognise the potential significance of one patient’s symptoms in one appointment is misconduct which is so serious that it calls into question his fitness to practise. Mr Archer submitted that it was not so grave as to cross that threshold.
80. The Committee received and accepted advice from the Legal Adviser. This included reference to a number of relevant authorities, including the following relevant principles from the judgment in the case of *Calhaem v General Medical Council [2007] EWHC 2606 (Admin)*:
- “(1) Mere negligence does not constitute “misconduct”. ... Nevertheless, and depending upon the circumstances, negligent acts or omissions which are particularly serious may amount to “misconduct”.*
- (2) A single negligent act or omission is less likely to cross the threshold of “misconduct” than multiple acts or omissions. Nevertheless, and depending upon the circumstances, a single negligent act or omission, if particularly grave, could be characterised as “misconduct”.*”
81. The Committee retired and considered its decision.
82. The Committee recognised and bore in mind throughout its deliberations, the important distinction between mere negligence, on the one hand, and conduct sufficiently serious to amount to misconduct, on the other.
83. The Committee accepted that the facts of this case relate to a single incident, namely the Registrant’s examination of Patient A on 4 May 2019. The Committee was satisfied, however, that the Registrant’s acts and omissions in the charges found proved can only properly be viewed as multi-faceted in nature. Moreover, those acts and omissions involved multiple breaches of the GOC’s Standards, which govern safe and effective practice.

84. The Committee was satisfied that the Registrant failed, at the outset of his examination, to take on board or recognise the potential seriousness of Patient A's reported symptoms of seeing dots, having a longstanding history of floaters and seeing her left cheek. This initial failure, in the Committee's judgment, in itself fell significantly below the standards to be expected of a Registrant. Those reported symptoms should, the Committee found, have acted as a red flag to any registered Optometrist. As Dr Kwartz stated, a comorbidity of reported symptoms in one eye should have "raised the index of suspicion" in the Registrant's mind. It is clear from the Registrant's contemporaneous record that Patient A informed him of all three of these highly significant symptoms at the outset of his examination, yet the Registrant failed to react appropriately. This involved failing to listen, in a meaningful and attentive way, to what he was being told by the patient, a failure to follow up symptoms with further questioning and investigation, and a failure to communicate effectively with her. It also involved a fundamental failure to carry out an adequate patient assessment or undertake the investigations and tests required.

85. The Committee was satisfied that the facts found proved involved multiple failures on the part of the Registrant to follow the GOC's 2016 Standards of Practice for Optometrists and Dispensing Opticians, as follows:

***"1. Listen to patients and ensure they are at the heart of the decisions made about their care***

*1.1 Give patients your full attention and allow sufficient time to deal properly with their needs.*

*1.2 Listen to patients and take account of their views, preferences and concerns, responding honestly and appropriately to their questions.*

*1.6 Consider all information provided by your patients.*

***2. Communicate effectively with your patients***

*2.1 Give patients information in a way they can understand. Use your professional judgement to adapt your language and communication approach as appropriate.*

***7. Conduct appropriate assessments, examinations, treatments and referrals***

*7.1 Conduct an adequate assessment for the purposes of the optical consultation, including where necessary any relevant medical, family and social history of the patient. This may include current symptoms, personal beliefs or cultural factors.*

*7.2 Provide or arrange any further examinations, advice, investigations or treatment if required for your patient. This should be done in a timescale that does not compromise patient safety and care.*

*7.5 Provide effective patient care and treatments based on current good practice.*

***8. Maintain adequate patient records***

*8.1 Maintain clear, legible and contemporaneous patient records which are accessible for those involved in the patient's care."*

86. The Committee also considered the College of Optometrists' Guidance and concluded that rather than A203 being relevant, A202 was not followed. This states *"if you carry out an examination you should continue until you detect a problem and can make a diagnosis or have sufficient evidence to decide what action to take."*
87. The Committee also took into account the potential seriousness of the consequences for Patient A's vision in her left eye, and of the Registrant's failure to appreciate that Patient A was reporting symptoms which should have been recognised by him as potential signs of a detached retina requiring further investigation. The Committee was satisfied that the potential for such consequences reflects the importance of adhering to the above Standards for safe practice.
88. In the light of the above considerations, the Committee concluded that the Registrants conduct, as found proved in the charges, fell far below the standards reasonably to be expected of a registered Optometrist and, as such, amounted to serious misconduct.

### **Impairment**

89. Having found that misconduct was established, the Committee went on to consider the issue of impairment.
90. Committee received further submissions from Mr Smart and Mr Archer.
91. For the Council, Mr Smart submitted that the Committee should conclude that the Registrant's fitness to practise is impaired by reason of his misconduct, both on the grounds of public protection and on the grounds that such a finding is required in order to uphold the public interest. Mr Smart accepted that the evidence of remediation in the form of his detailed CPD/CET training records should be weighed in the Registrant's favour. Mr Smart also submitted there was scant evidence of insight. He agreed there was some evidence of remediation but this had to be seen in the light of the Registrant's assertion that he had done nothing wrong. Mr Smart also submitted that the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in this case.
92. For the Registrant, Mr Archer reminded the Committee that the purpose of fitness to practise proceedings is not to punish the Registrant for past misdoings, but to protect the public against the acts and omissions of those who are not fit to practise. Mr Archer submitted that it would be wrong to assume that, because the Registrant contested the allegation, he does not have insight. Mr Archer submitted that these proceedings have had the effect of focusing the mind of the Registrant, and motivating him to consider whether there are gaps in his knowledge or failings that he needs to correct. Mr Archer referred to the extensive training the Registrant had undertaken since the event in question. The fact that he had so assiduously sought to remediate the errors that occurred in May 2019 was, Mr Archer submitted, strong evidence of both insight and remediation. The misconduct found proved was an isolated incident after 30 years of successful practice. The Registrant had continued to practise since that time without any further complaints against him.

93. The Committee heard and accepted the advice of the Legal Adviser, who referred to the cases of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council (2) Grant* [2011] EWHC 927 (Admin), *Cohen v GMC* [2009] EWHC 645 (Admin).

94. The Committee bore in mind that, under Section 1 of the Opticians Act 1989, the Council has the general function of promoting high standards of professional education, conduct and performance among registrants and that its main objective is to protect, promote and maintain the health, safety and wellbeing of the public.

95. In this regard the Committee considered the judgment of Mrs Justice Cox in the case of *Grant*. In reaching the Court's decision, in paragraphs 74 and 75 she said:

*"In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances."*

96. Mrs Justice Cox went on to say in paragraph 76 of the judgment:

*"I would also add the following observations in this case having heard submissions, principally from Ms McDonald, as to the helpful and comprehensive approach to determining this issue formulated by Dame Janet Smith in her Fifth Report from Shipman, referred to above. At paragraph 25.67 she identified the following as an appropriate test for panels considering impairment of a doctor's fitness to practise, but in my view the test would be equally applicable to other practitioners governed by different regulatory schemes."*

*"Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her fitness to practise is impaired in the sense that s/he:*

- a. has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or*
- b. has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or*
- c. has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or*
- d. [Not applicable]."*

97. In its consideration of whether the Registrant has remedied the deficiencies in his practice, the Committee took into account the three questions identified in *Cohen*, namely: *'Is the conduct easily remediable? Has it been remedied? Is it highly unlikely to be repeated?'*

98. The Committee was satisfied that the Registrant had in the past acted so as to put Patient A at unwarranted risk of harm. This finding clearly followed from the Committee’s findings of fact in relation to the allegation. The Committee also accepted that the facts of the allegation would in the past have had a damaging effect on the profession. The Committee also concluded that the Registrant had in the past breached a fundamental tenet of the profession; in its findings on misconduct, the Committee had found that a number of fundamental professional standards had been breached.
99. With regard to the first question from Cohen, the Committee considered that the deficiencies in the Registrant’s conduct should, in principle, be easily remediable. They all related to skills which should be amenable to retraining. The key questions were whether they had been remedied, and whether they were highly unlikely to be repeated. The same questions were relevant to the issue of whether the above limbs a., b. and c. of the test from Grant were engaged with regard to the future.
100. The Committee in this respect considered whether, and if so to what extent, the Registrant had shown evidence of insight, remorse and remediation in relation to his practice. The Committee took into account the following passage from the judgment in Grant:
- “When considering whether fitness to practise is currently impaired, the level of insight shown by the practitioner is central to a proper determination of that issue.”*
101. The Committee accepted that the fact that the Registrant had, throughout, denied all the allegations did not, in principle, preclude him from demonstrating insight. However, the fact that he had not accepted that he had made any error might make it more difficult for him to do so.
102. The Committee recognised that, whilst the Registrant had denied the allegations in this case, they had clearly acted as a powerful catalyst for a substantial application on his part to training, much of which was focused specifically in the concerns arising from the allegation. The Committee took into account all the evidence relating to this training. Mr Archer, in his submissions, helpfully summarised that training in the following terms:
- “You have his current CPD record. You can see that Mr Asuen has taken the initiative to fill any gaps in his knowledge. He has gone above and beyond what is required. His current CPD period runs from 2022 until 2024. But he has already undertaken nearly twice as many CPD points as he is required to do for that entire period. The 67 points that he has completed were all from approved providers, notwithstanding that he is only required to complete 18 points via approved providers, 37 points are attributable to interactive activities where Mr Asuen played an active role in the discussions.*



*You will see that many of Mr Asuen’s CPD points were achieved through the training for the Professional Certificate in Medical Retina qualification. We have provided information about the course provided by City University and accredited by the College of Optometrists. (The information relates to the course running from January 2023, but the substance is the same as the course that Mr Asuen attended in 2022). The course used a mix of blended learning and three full days of face-to-face teaching, which ran back-to-back and consisted of lectures, practical workshops and case discussions. Mr Asuen selected this course because it addresses the areas of knowledge that are relevant to the allegation in these proceedings.”*

On that course, Mr Asuen received additional training that included the following topics:

- a. The physiology and anatomy of the healthy retina;
- b. Communication with patients;
- c. The pathophysiology, risk factors, and differential diagnosis of retinal and macular pathology;
- d. Current treatments of medical retina disorders;
- e. OCT imaging and fundus photographs in the healthy eye and in ocular pathology;
- f. Fluorescein angiography, ICG angiography and autofluorescence imaging in the healthy eye and in pathology;
- g. Demonstrate a critical awareness of current national referral guidelines and a detailed knowledge of local referral pathways.
- h. The course also covered topics a number of topics relating to diabetes.

The course was assessed, the assessment taking place 8 weeks after the face-to-face teaching. The assessment involved a three-hour written assessment and six Objective Structured Clinical Examinations over a period of one hour. Having completed the course, Mr Asuen was able to:

- a. Demonstrate a detailed knowledge of the anatomy, physiology and pathophysiology of the retina, with emphasis on the macular;
- b. Demonstrate an in-depth understanding of the risk factors and differential diagnosis of disorders of the retina and macular pathology;
- c. Demonstrate a critical understanding of treatments of medical retina disorders, including the patient’s response to treatment;
- d. Demonstrate a critical awareness of the use of fluorescein, ICG angiography, and autofluorescence;
- e. Demonstrate an in-depth understanding of the principles, processes and protocols of national diabetic retinopathy screening programmes;

- f. Demonstrate an in-depth understanding of diabetes and its relevance to diabetic retinopathy screening.
- g. Demonstrate a critical awareness of current national referral guidelines and a detailed knowledge of local referral pathways;
- h. Demonstrate a critical awareness of the rapidly evolving nature of medical retinal treatments, including pertinent treatment trials
- i. Demonstrate an in-depth understanding of current guidelines for management of MR disorders.

After completing the course, Mr Asuen was able to:

- a. Show an ability to communicate effectively with patients;
  - b. Show an advanced ability to critically interpret OCT images and fundus photographs for AMD and diabetic retinopathy, with appropriate patient management;
  - c. Show an expert ability to detect and classify diabetic retinal disease;
  - d. Show a comprehensive ability to recognise acute retinal pathology, conduct appropriate tests and make appropriate referrals, clearly stating the level of urgency.”
103. The Committee was satisfied that the training referred to above was both extensive and relevant to the allegations found proved. The Committee was sufficiently reassured by the above evidence of training, the fact that the events giving rise to this referral could be seen as an isolated occurrence in an otherwise lengthy and unblemished career and the fact that no further complaints had arisen since the incident almost four years ago. It therefore concluded that the likelihood of repetition was extremely low.
104. The Committee also took into account the Registrant’s written evidence:
- “I have taken this investigation very seriously and I have completely respected the process and have taken this as a learning experience. I have always been committed to improving my skills.”*
105. The Committee accepted that the proceedings in this case, including a lengthy hearing, have had a salutary effect on the Registrant.
106. Accordingly, the Committee concluded that limbs a., b. and c. of the Grant test were not engaged as to the future. Furthermore, the Committee decided that the second and third questions from Cohen above should be answered in the affirmative.
107. The Committee was therefore satisfied that a finding of current impairment on the grounds that this was necessary for the purpose of protecting the public was not required.

108. Regarding insight, the Committee was disappointed that it had not received any evidence from the Registrant consisting of an expression of remorse on his part for any harm caused to Patient A. However, the Committee considered, on balance, that it would be disproportionate to find impairment for this reason alone.
109. The Committee also carefully considered whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances of this case.

Having regard to its findings set out in paragraph 103 above, the Committee decided that a finding of current impairment was not required on public interest grounds alone. The Committee considered that a fair-minded member of the public, properly informed as to the salient facts of this case, would not expect such a finding to be made. In its consideration of the public interest, the Committee had regard to the following passage from the judgment in *Grant*:

*“I regard that as an important consideration in cases involving fitness to practise proceedings before the NMC where, unlike such proceedings before the General Medical Council there is no power under the rules to issue a warning, if the committee finds that fitness to practise is not impaired. As Ms McDonald observes, such a finding amounts to a complete acquittal, because there is no mechanism to mark cases where findings of misconduct have been made, even where that misconduct is serious and has persisted over a substantial period of time. In such circumstances the relevant panel should scrutinise the case with particular care before determining the issue of impairment.”*

110. Whilst the Committee, therefore, concluded that the Registrant’s fitness to practise is not currently impaired by reason of his misconduct, it went on to consider its powers under Section 13F(5) to give a warning in a case where a finding of no impairment is made.
111. The Committee decided that it is minded to give such a warning. The Committee invites the parties to make representations with regard to any such warning before a final decision is made.



## Warning

112. Having indicated in its findings on impairment that it was minded to give the Registrant a Warning as to his future conduct or performance, the Committee heard submissions from the parties with regard to any such Warning.
113. Mr Smart submitted that a Warning was entirely appropriate in this case because the Committee had concluded that the allegations found proved amounted to serious misconduct, but the threshold for a finding of impairment had not been met. A Warning would allow the Registrant to continue without disruption to his practice, whilst marking the seriousness of the misconduct. Mr Smart referred to the relevant part of the Council's Indicative Sanctions Guidance. He submitted that the Warning should be for 12 months.
114. Mr Archer on behalf of the Registrant did not accept that a Warning was necessary in this case. He submitted that a Warning would be a serious matter for the Registrant, as it would be accessible on the Council's website. However, if the Committee decided to issue a Warning, Mr Archer submitted that it should be for a much shorter period than 12 months.
115. The Committee heard and accepted the advice of the Legal Adviser, who referred to Section 13F(5) of the Opticians Act 1989 and to the relevant part of the Council's Indicative Sanctions Guidance.
116. The Committee carefully considered whether a Warning was necessary and appropriate.
117. The Committee was satisfied that a Warning should be given in this case to indicate that the misconduct found proved represented a serious departure from the standards expected of its registrants and should not be repeated. Further, a Warning was required to highlight to the profession and to the public that conduct of the kind found proved in this case is unacceptable.
118. The Committee had regard to the following passage from the Council's Indicative Sanctions Guidance:

*"20.6 Factors when a finding of no impairment has been made and a Warning may be appropriate:*

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

*20.7 If the Committee are satisfied that the registrant's fitness to practise is not impaired."*

119. The Committee was satisfied that all the above factors were evident in this case.



120. The Committee decided to give the Registrant a Warning as follows:

*“You must listen to your patients carefully to explore, investigate and record their presenting symptoms thoroughly. Failure to do so may lead to a future finding of impairment by a Fitness to Practise Committee. You are specifically reminded to adhere to the Standards of Practice for Optometrists and Dispensing Opticians, in particular:*

*Standard 1: Listen to patients and ensure that they are at the heart of the decisions made about their care.*

*Standard 2: Communicate effectively with your patients.*

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

*Standard 8: Maintain adequate patient records”*

121. The duration of this Warning will be for 12 months, so that it will expire on 12 January 2024.

**Chair of the Committee: Graham White**

**Signature**

**Date: 13 January 2023**

**Registrant: John Asuen**

**Signature** present via video.....

**Date: 13 January 2023**



<b>FURTHER INFORMATION</b>
<b>Transcript</b>
A full transcript of the hearing will be made available for purchase in due course.
<b>Appeal</b>
Any appeal against an order of the Committee must be lodged with the relevant court within 28 days of the service of this notification. If no appeal is lodged, the order will take effect at the end of that period. The relevant court is shown at section 23G(4)(a)-(c) of the Opticians Act 1989 (as amended).
<b>Professional Standards Authority</b>
<p>This decision will be reported to the Professional Standards Authority (PSA) under the provisions of section 29 of the NHS Reform and Healthcare Professions Act 2002. PSA may refer this case to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court of Justice in Northern Ireland as appropriate if they decide that a decision has been insufficient to protect the public and/or should not have been made, and if they consider that referral is desirable for the protection of the public.</p> <p>Where a registrant can appeal against a decision, the Authority has 40 days beginning with the day which is the last day in which you can appeal. Where a registrant cannot appeal against the outcome of a hearing, the Authority's appeal period is 56 days beginning with the day in which notification of the decision was served on you. PSA will notify you promptly of a decision to refer. A letter will be sent by recorded delivery to your registered address (unless PSA has been notified by the GOC of a change of address).</p> <p>Further information about the PSA can be obtained from its website at <a href="http://www.professionalstandards.org.uk">www.professionalstandards.org.uk</a> or by telephone on 020 7389 8030.</p>
<b>Contact</b>
If you require any further information, please contact the Council's Hearings Manager at 10 Old Bailey, London, EC4M 7NG or, by telephone, on 020 7580 3898.