

# Optometry and Malpractice

## Definition of malpractice

3 Factors must be present:

- 1) Professional care rendered needs to be below the generally accepted standard of care  
(AOA Practice Guidelines may often be used as the standard)
  - 2) Patient must suffer a loss – usually irreversible loss of vision or loss of life
  - 3) Connection must exist between what the clinician failed to do and the loss suffered  
In general, a clinician isn't held responsible for missing a dx of an untreatable disorder (e.g. Retinitis Pigmentosa)
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## Majority of malpractice cases fall within 3 categories

- 1) Retinal detachment
- 2) Glaucoma
- 3) Tumors

less frequently: diabetic retinopathy, choroidal neovascularization, etc.

## Details to Cover During Routine Optometric Examination

### A) Best Corrected Visual Acuity

- should be 20/20
- if not, why? cataracts, funduscopy: check the macula and the optic nerve
- Amblyopia is a diagnosis of exclusion and basically has 3 causes
  - \*3 Causes: refractive error, (constant) strabismus, or occlusion (eg. Ptosis, a severe cataract, etc)
  - \*The doctor still needs to do all other ocular health testing: IOP, SLE, DFE, VF, etc.\*

### B) Intraocular Pressure

- should be done on all patients (at most/all visits)
  - Exceptions: FB where tonometer tip applanates, corneal denuded
  - ALWAYS: before you commence with a steroid and at follow-up visits while using a steroid

### C) Fundus Examination (Dilated!)

- realize that external “red eyes” can have intraocular causes!

### D) Visual Field:

- consider automated since the printout provides medico-legal documentation

### E) Follow-up examination

- when in doubt, see the patient again (you don't have to wait a year!)