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.

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**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!)