STATE OF MAINE
BOARD OF OPTOMETRY

IN RE:	)	
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ROBERT F. MURRAY, III O.D.	)	SECOND REVISED
	)	
	)	CONSENT AGREEMENT
	)	
Complaint No. 2021-OPT-17405	)	
Complaint No. 2021-OPT-17652	)	
	)	

INTRODUCTION

This document is a Revised Consent Agreement, effective when signed by all parties hereto, regarding the license of Robert F. Murray, III, O.D. ("Dr. Murray") to practice optometry in the State of Maine. The parties to this Revised Consent Agreement are Dr. Murray, the Maine State Board of Optometry ("the Board"), and the Office of the Maine Attorney General ("the Attorney General"). The parties consent to this Agreement, pursuant to 10 M.R.S. § 8003(5)(B) in lieu of an adjudicatory hearing in the above referenced complaints.

STATEMENT OF FACTS

1. On June 10, 1975, the Board first licensed Dr. Murray to practice optometry in the State of Maine, license number OPT580.

2. From December 20, 2006 to the present, Dr. Murray's license level is the Therapeutic Advanced Glaucoma level license that authorizes him to diagnose and treat glaucoma.

3. At all relevant times, Dr. Murray worked as an Optometrist at South Paris Eyecare, P.A.

FACTS PERTINENT TO 2021-OPT-17405

4. In the course of his practice at South Paris Eyecare, Dr. Murray saw Patient A on 8/20/2020 and 9/8/2020.

5. The medical records for both August and September 2020 visits were eSigned on 4/6/21.

6. Dr. Murray's records of 8/20/2020 indicate that Patient A was seen for blurry vision, left worse than right. Her examination findings are as follows:

   a. Using a handheld I care tonometer, Dr. Murray's reports reflect an Intraocular Pressure (IOP) of "2" in her right eye with a pressure of "13" in her left eye.

   b. An FDT test showed normal visual field in both eyes.

   c. Slit lamp examination showed CD ratio .8 OD and .75 OS but elsewhere in the report, Dr. Murray noted that the optic disc was flat and normal.

   d. Dr. Murray notes in the conclusion that there is asymmetric IOP but did not flag the pressure reading of "2" in the right eye as abnormal or an area of concern.

   e. The record lacks an assessment regarding the disparity between the eye pressures and regarding the very low right eye pressure.

   f. The record lacks a family history.

7. At this first visit, Dr. Murray reached a diagnosis of bilateral glaucomatous optic atrophy and told Patient A to come back for more testing.

8. At the second visit on September 8, 2020, the record reflects that the only tests administered were the ERG/VEP tests.

a. The records from the ERG/VEP tests show that "all tests failed" and it appears that a prescription for pressure-lowering drops was issued for both eyes, including the eye which had previously measured with IOP of "2."

b. The records do not reflect that any of the following examinations or tests were administered on September 8, 2020: Family history, visual acuity, pupils, bio microscopy, tonometry, pachymetry, gonioscopy, optic nerve assessment, nerve fiber layer assessment, peripapillary area assessment, fundus photography, and visual fields, use of applanation tonometry, or Optical Coherence Tomography (OCT).

9. At this second visit, Patient A reports being given the diagnosis of glaucoma and a prescription for medication. Patient A reports getting no material to read and no education on the diagnosis.

10. Patient A filled the prescription immediately and, although the medical records and the Dr. Murray's response said that she was to return in a month, she reports not being told to secure an appointment and further reports being denied an appointment when she and her husband called. There is no record of follow up calls to Patient A to set up appointment and Patient A was not seen again by Dr. Murray.

11. On follow-up inquiry by the Board, Dr. Murray stood by both his assessment of an IOP of 2 in the right eye and his prescription of pressure reducing drops for that eye, stating that glaucoma is a bilateral condition with pressure spikes while patients sleep. Noting that a 20% drop in pressure typically results from use of Latanoprost, pressure reducing medication, he noted that an expected IOP target in the right eye of 1.6.

12. The AOA Clinical Practice Guideline "Care of the Patient with Open Angle Glaucoma" identifies a variety of testing methods useful in the diagnosis of open angle glaucoma.[1] These methods include visual acuity, pupils, bio microscopy, tonometry, pachymetry, gonioscopy, optic nerve assessment, nerve fiber layer assessment, peripapillary area assessment, fundus photography, and visual fields. The AOA Clinical Practice Guideline "Care of the Patient with Open Angle Glaucoma" goes on to say that: Other procedures may be used to detect the earliest loss of visual function from glaucoma. Although measurement of color vision, contrast sensitivity, and dark adaptation, in addition to pattern electroretinograms and visual evoked potentials, have been thoroughly studied, none has proven ability to distinguish glaucoma suspects from individuals with Open Angle Glaucoma. [2]

13. Dr. Murray relied heavily on electrophysiology testing, that is, electro-retinograms (ERGs) and visual evoked potentials (VEPs) are used to assess glaucoma as an early detection technology. The VEP used was multicontrast VEP. Dr. Murray indicates that VEP can detect glaucoma 8 years before OCT testing. He did not use any of the other tests listed by the AOA in the follow up visit of September 8, and only a handheld tonometry reading and screening visual field test at the 8/20/2020 visit.

14. A review of the AOA standards for the diagnosis of glaucoma supports a variety of tests to diagnose glaucoma, none of which include ERG/VEPs. Although the evolution of the

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[1] https://www.aoa.org/aoa/documents/practicemanagment/clinicalguidelines/consensus-basedguidelines/careofthepatientwithopenangleglaucoma.pdf Microsoft Word - CPG 9 Open Angle Glaucoma Guideline-MWedit-FINAL REVISION.doc (aoa.org), pp. 24 – 31.

[2] Microsoft Word - CPG 9 Open Angle Glaucoma Guideline-MWedit-FINAL REVISION.doc (aoa.org), p. 32.

technology is promising for the future, it is not considered sufficiently reliable according to current literature to be considered the standard of care, especially used alone.

VIOLATIONS OF COMMONLY UNDERSTOOD STANDARDS OF PROFESSIONAL BEHAVIOR PERTINENT TO 2021-OPT-17405

15. Dr. Murray violated commonly understood standards of professional behavior by signing medical records on April 6, 2021 for visits of August 20, 2020 and September 8, 2020.

16. Dr. Murray violated commonly understood standards of professional behavior by diagnosing glaucoma but:

a. not undertaking adequate testing to reach a reliable diagnosis of glaucoma; and

b. relying too heavily on technology that has not yet been found reliable;

17. Dr. Murray violated commonly understood standards of professional behavior by not creating an adequate treatment and management plan regarding Patient A's critically low intraocular pressure of 2 including:

a. prescribing pressure-reducing medication in an eye with an eye pressure of "2;"

b. not evidencing appropriate sense of urgency regarding an intraocular pressure of 2 in the right eye; and

c. not retesting intraocular pressure at the second visit; and

d. not providing education to Patient A regarding the risks of low eye pressure, also known as hypotony.

18. Dr. Murray violated commonly understood standards of professional behavior by not creating an adequate treatment and management plan for glaucoma including not scheduling any follow up for the new diagnosis after prescribing pressure lowering drops.

19. Dr. Murray violated commonly understood standards of professional behavior by not providing adequate education to Patient A regarding her new diagnosis of glaucoma.

FACTS PERTINENT TO 2021-OPT-17652

20. In the course of his practice at South Paris Eyecare, Dr. Murray saw Patient B on August 20, 2020; August 25, 2020; October 1, 2020; and April 7, 2021.

21. Patient B has diabetes and at the time of the first two visits was 26 years old; at the time of the last two visits, the patient was 27 years old.

22. At no point in his care of Patient B did Dr. Murray inquire as to family history of glaucoma.

23. On the 8/20/20 visit, Patient B's IOP readings were OD: 27 and OS: 26 using Non-Contact Tonometry (NCT). Automated visual field testing was not reflected as having occurred at this visit. Cup to Disc ratio was recorded at .25 and .25. Dr. Murray told Patient B that she had glaucoma; he prescribed Latanoprost; and he told her to come back for more testing.

24. She returned on August 25, 2020 when the only tests administered were the ERG and VEP testing. At that visit, no IOP readings or visual field testing was undertaken. The records do not reflect that any of the following examinations or tests were administered on August 25, 2020: Family history, visual acuity, pupils, biomicroscopy, tonometry, pachymetry, gonioscopy, optic nerve assessment, nerve fiber layer assessment, peripapillary area assessment, fundus photography, use of applanation tonometry, or Optical Coherence Tomography (OCT).

25. Dr. Murray did not explain what glaucoma was or what it meant for her and the future of her eyes at either the August 20, 2020 or August 25, 2020 visit. Patient B acknowledges that Dr. Murray told her that her eyes were failing and she was left with the impression that her eyesight would be affected "a little down the road."

26. Complainant returned 10/1/2020 and the handheld tonometer reading was 22 and 26 IOP at that time. The records do not reflect that any of the following examinations or tests were administered on October 1, 2020: Family history, visual acuity, pupils, bio microscopy, tonometry (other than hand held tonometry), pachymetry, gonioscopy, optic nerve assessment, nerve fiber layer assessment, peripapillary area assessment, fundus photography, and visual fields, use of applanation, or Optical Coherence Tomography (OCT)

27. On April 7, 2021, Dr. Murray saw complainant for the last time. At that visit, IOP was OD: 17 and OS: 27 via handheld tonometer and visual field was normal. A dilated exam of the optic disc was performed and the CD ratio was reported to be .8 bilaterally, a reading in contrast to the reading of Patient B's CD ratio of August 20, 2020 which was .25 OU. The optic disc was described as flat and normal. An automated perimetry visual field test was used and OU findings were normal and OU reliability was good.

28. Because Dr. Murray did not provide adequate education regarding the diagnosis of glaucoma, Patient B did her own on-line research. She was distressed at the potential of glaucoma worsening with diabetes and pregnancy. Based on their research, she and her husband decided not to have more children, changing their plan to have more than one child. Accordingly, her husband had a vasectomy in the spring of 2021.

29. Complainant had been seen by another optometry group in April 2019 (before her visits with Dr. Murray) and then in July and August 2021 (after her visits with Dr. Murray).

a. On April 10, 2019, before her visits to Dr. Murray, the other optometry group did an applanated IOP assessment and found that her intraocular pressures were OD: 19 and OS: 19. Her eye exam at that time was considered "Healthy eye exam."

b. On July 1, 2021, her applanated intraocular pressures were 16 and 18. One month later on August 12, 2021, her applanated intraocular pressures were 18 bilaterally. Pachymetry was performed and Patient B was found to have slightly thicker than average corneas. At that time, Patient had a full visual field in both eyes. After discussion, complainant started a medication holiday from the pressure reducing medication prescribed by Dr. Murray.

c. On October 27, 2021 following a medication holiday, Patient B's intraocular pressure was 24 in both eyes before adjustment for corneal thickness. A glaucoma specialist at the practice of the other optometry group conferred and, in light of Patient B's thicker corneas, unremarkable glaucoma testing, and healthy optic nerve appearance, the decision was made to monitor intraocular pressure and not reinstate pressure reducing drops.

30. The American Optometric Association recommends that in the diagnosis of glaucoma, a practitioner use some combination of visual acuity, pupils, bio microscopy, tonometry, pachymetry, gonioscopy, optic nerve assessment, nerve fiber layer assessment, peripapillary area assessment, fundus photography, and visual fields (see footnote 1). In

Complainant's case, none of the preceding tests were done except a handheld tonometer readings and screening visual field testing.

31. ERG and VEP are not yet considered reliable in the standards set forth by the AOA (see footnote 2).

VIOLATIONS OF COMMONLY UNDERSTOOD STANDARDS OF PROFESSIONAL BEHAVIOR PERTINENT TO 2021-OPT-17652

32. Dr. Murray violated commonly understood standards of professional behavior in the diagnostic process by not undertaking adequate testing to reach a reliable diagnosis of glaucoma, with the specific omission of combination of visual acuity, pupils, biomicroscopy, tonometry, pachymetry, gonioscopy, optic nerve assessment, nerve fiber layer assessment, peripapillary area assessment, fundus photography, and visual fields;

33. Dr. Murray violated commonly understood standards of professional behavior in the diagnostic process by not undertaking adequate testing to reach a reliable diagnosis of glaucoma by relying too heavily on technology that has not yet been found reliable in the diagnosis of glaucoma;

34. Dr. Murray violated commonly understood standards of professional behavior in the diagnostic process by diagnosing glaucomatous optic atrophy versus ocular hypertension;

35. Dr. Murray violated commonly understood standards of professional behavior in by not creating an adequate treatment and management plan regarding Patient B's condition; and

36. Dr. Murray violated commonly understood standards of professional behavior by not providing adequate education to Patient B regarding her new diagnosis of glaucoma.

37. Dr. Murray violated commonly understood standards of professional behavior by not for not meeting the standards for a minimum eye exam pursuant to 32 M.R.S. § 2417(3).

COVENANTS

38. Dr. Murray admits to the facts as set forth above and admits that his conduct constitutes grounds for the Board to impose discipline against his license under the following provisions:

a. Pursuant to 32 M.R.S. § 2431-A(2), the Board may impose discipline on any of the following bases:

i. 32 M.R.S. § 2431-A(2)(F) provides that a licensee is considered to have engaged in unprofessional conduct if the licensee violates a commonly understood standard of professional behavior or board rule governing professional conduct.

39. Dr. Murray engaged in unprofessional conduct as described in paragraphs 15, 16, 17, 18, 19, 32, 33, 34, 35, 36, and 37.

40. The Board has authority to enter into this Revised Consent Agreement pursuant to 10 M.R.S. § 8003(5)(B).

SANCTIONS

41. As DISCIPLINE for the violation admitted to in paragraph 39, Dr. Murray agrees to accept the following:

a. A REPRIMAND.

b. LICENSE MODIFICATION. Dr. Murray's license shall be modified from a Therapeutic Advanced Glaucoma license to a Therapeutic Advanced license level. Accordingly, Dr. Murray shall not diagnose or treat glaucoma without further action by the Board.

c. PROBATION. Dr. Murray agrees that **his license to practice will be probationary for a minimum of one year beginning March 28, 2022.** During the period of probation, his license shall be subject to the following conditions:

i. **ADDITIONAL CONTINUING EDUCATION.** During the period of probation, Dr. Murray shall undertake 25 hours of continuing education on the diagnosis, treatment, and management of patients with glaucoma. These additional hours may not be used towards any continuing education required for license renewal.

ii. **DISCIPLINARY SUPERVISION.** Dr. Murray has submitted, and the Board has approved as of February 17, 2022, Maria Diaz O.D. Dr. Diaz is a licensed optometrist in the State of Maine in good standing for at least five (5) years as of March 28, 2022. She is licensed at the Therapeutic Advanced Glaucoma level. The Supervisor remain licensed and must remain independent of Dr. Murray's place of employment and must have no personal or professional connection to him. **All costs of supervision are to be borne by Dr. Murray.**

iii. Dr. Murray is responsible for ensuring that, within fifteen (15) days of the Board's approval of the Supervisor (February 17, 2022) the Supervisor submits a letter of intent evidencing: their understanding of the Revised Consent Agreement; familiarity with the circumstances surrounding the underlying complaint; acknowledgment of the purposes of the supervision; and an agreement to bring forth any ethical or legal concerns regarding Dr. Murray's practice.

iv. The following CPT codes shall hereinafter be referred to as the glaucoma CPT codes:
   (a) Primary Open Angle Glaucoma: H40.1111 to H40.1133
   (b) Glaucomatous Optic Atrophy: H47.239
   (c) Glaucoma Suspect: H40.00
   (d) Glaucoma Suspect Low Risk: H40.01
   (e) Glaucoma Suspect High Risk: H40.02
   (f) Ocular Hypertension: H40.05

v. Dr. Murray shall ensure that the Disciplinary Supervisor reports in writing to the board at its quarterly meetings. The Disciplinary Supervisor's report shall include an assessment of at least **30 randomly selected files at the**

Board's meeting on August 5, 2022 and at least 15 randomly selected patient files at each of the Board's meetings on November 4, 2022 and in February 2023 (date to be established). Each of the files reviewed and reported on by the Disciplinary Supervisor shall have any one of the glaucoma CPT codes listed in paragraph (iv.) above.

vi. The Disciplinary Supervisor will specifically address the quality and completeness of Dr. Murray's recordkeeping, diagnoses, and treatment plans, and whether the standards of practice are met in recordkeeping, diagnosis, and treatment plans.

vii. Prior to each board meeting, Dr. Murray and the Disciplinary Supervisor shall review the findings of the Disciplinary Supervisor in person, telephonically, or via video conference at the discretion of the Disciplinary Supervisor.

viii. After the Board has reviewed written presentations at 3 meetings and the assessment reporting on at least 60 of Dr. Murray's patient files with glaucoma CPT codes, Dr. Murray may petition the Board for modification of his license back to the level of Therapeutic Advanced Glaucoma license. Dr. Murray agrees that the Board retains full discretion in determining whether to modify Dr. Murray's license back to Therapeutic Advanced Glaucoma level or not and further that the Board retains discretion to extend probation for such additional time the Board determines appropriate as permitted by 10 M.R.S. § 8003(5)(A-1(4) to permit the Disciplinary Supervisor to review diagnosis and treatment plans for up to 15 patients per quarter and report to the Board regarding diagnosis and treatment plan for patients with any of the glaucoma CPT codes until either Dr. Murray petitions the Board to end probation or that the Board identifies that the Disciplinary Supervision is no longer necessary.

ix. The Disciplinary Supervisor may at any time indicate to the Board or Board staff that she has information that causes the Disciplinary Supervisor to reasonably believe that Dr. Murray might be suffering from a mental illness or physical illness that may be interfering the competent practice of optometry. In such an event, the Board may order a psychological or physical evaluation. **Cost of any evaluation shall be the responsibility of the Dr. Murray.**

42. Dr. Murray's violation of any term or condition of this Revised Consent Agreement may be found by the Board to be grounds for additional discipline against his license including without limitation possible monetary penalties, license suspension, or license revocation.

43. The Board and Dr. Murray agree that no further agency action will be initiated against his license by the Board based upon the specific violations admitted to herein, except or unless he fails to comply with the terms and conditions of this Revised Consent Agreement. The Board may, however, consider the conduct described above as evidence of a pattern of misconduct in the event that other allegations are brought against Dr. Murray, and this Revised Consent Agreement may be introduced as evidence in any future adjudicatory hearing involving Dr. Murray. The Board may also consider the fact that discipline was imposed by this Revised Consent Agreement in determining appropriate discipline in any further complaints against Dr. Murray.

44. This Revised Consent Agreement is not appealable and is effective until amended or rescinded in writing by agreement of all the parties hereto. This Revised Consent Agreement cannot be amended verbally.

45. Requests for amendment of this Revised Consent Agreement must be made in writing and submitted to the Board. The Board may deny such a request, grant such a request, or grant such a request in part. A Board decision regarding a request to modify this Revised Consent Agreement need not be made pursuant to a hearing and is not appealable to any court.

46. The Board and the Office of the Attorney General may communicate and cooperate regarding any matter related to this Revised Consent Agreement.

47. This Revised Consent Agreement is a public record within the meaning of 1 M.R.S. § 402(3) and will be available for inspection and copying by the public pursuant to 1 M.R.S. § 408-A.

48. Nothing in this Revised Consent Agreement shall be construed to affect any right or interest of any person not a party hereto.

49. This Revised Consent Agreement constitutes the entire agreement between and among the parties regarding the referenced complaint.

50. This Revised Consent Agreement may be signed in counterparts and all counterparts together constitute one original instrument. Signatures below may be applied and/or saved electronically and given the same effect as a paper document signed in ink.

51. This Revised Consent Agreement constitutes adverse action and is reportable to the National Practitioner Data Bank ("NPDB").

52. If any provision of this Revised Consent Agreement is for any reason determined to be invalid, the effectiveness and enforceability of all other provisions of the Revised Consent Agreement shall not be affected by such determination.

53. This Revised Consent Agreement becomes effective on the date of the last signature hereto.

54. Dr. Murray acknowledges by his signature hereto that he has read this Revised Consent Agreement, that he has had an opportunity to consult an attorney before signing this Revised Consent Agreement, that he signed this Revised Consent Agreement of his own free will and without undue influence of any kind from any person, and that he agrees to abide by all terms and conditions set forth herein.

[Signatures on the following page.]

SIGNATURES

Dated: 5-18-22

ROBERT F. MURRAY, III, O.D.

MAINE BOARD OF OPTOMETRY, by

Dated: 06/07/22

THOMAS NADEAU, O.D.,
Board President

OFFICE OF THE ATTORNEY GENERAL, by

Dated: 6-21-22

ELIZABETH W. STIVERS
Assistant Attorney General