Ophthalmologist, Dr B /

Ophthalmology Department

Eye Clinic at a Public Hospital

A Report by the

Health and Disability Commissioner

(Case 00HDC09046)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer / Complainant
Dr B	Provider / Ophthalmologist
Dr C	Ophthalmologist
Dr D	Ophthalmic Registrar
Dr E	Ophthalmic Registrar
Dr F	Ophthalmologist, with external eye expertise
Dr G	Ophthalmic Registrar
Dr H	Ophthalmic Registrar
Professor I	Clinical Director, Ophthalmology Department Eye Clinic at the public hospital
Dr J	Ophthalmic Registrar
Dr K	Oculoplastic Surgeon / Ophthalmologist

Independent expert advice was obtained from an ophthalmologist, Professor R S Clemett.

Complaint

The Commissioner received a complaint from Mr A concerning the management, and standard of care and treatment that he received from Dr B and other ophthalmologists of an eye clinic at a public hospital. Mr A's complaint was detailed in his complaint letter and is summarised as follows:

- *For a number of years, Mr A has been an out-patient at the public hospital's Ophthalmology Department Eye Clinic (the Eye Clinic) for the treatment and management of carcinoma-in-situ of the left eye. Mr A had a series of surgical treatments over several years and was informed in a regular follow-up visit that the cancer had been removed. Mr A subsequently found out that this was not the case.*
- *On 13 June 2000 Mr A acutely visited the Eye Clinic at the public hospital and was advised by an ophthalmologist who examined his left eye that an urgent follow-up appointment would be made "as soon as possible". Mr A was told that he would have to accept and could not change an already scheduled appointment for 20 July 2000. The appointment for 20 July 2000 was subsequently postponed until 31 August 2000.*
- *On 31 August 2000, Dr B told Mr A that his left eye would be removed as the cancer was widespread and the eye was beyond treatment. This was the first time that Mr A had ever heard of the tissue that had been visibly spreading over his left eye, described as cancer.*
- *Mr A is concerned that he was never offered the option of restoring his left eye to good health by transferring tissue from his right eye to his left eye.*
- *Mr A is concerned that if previous surgical treatment had left his eye free of cancer for a substantial period of perhaps two years or more, why was the subsequent management not effective in keeping his eye free of cancer? Mr A alleges that:*

- *After the surgery, and with the known possibility of recurrence of cancer in his left eye, follow-up monitoring was not adequate or effective and his left eye was not seen often enough. Too long a period of time was allowed between monitoring appointments in spite of his attempts to get more frequent and urgent attention. This is a major causal factor of the final outcome and why his left eye must now be removed.*
- *The Ophthalmology Department's administrative system did not respond as it should have to the urgency expressed by Mr A, the patient, of his condition.*
- *The Ophthalmology Department's administrative system is culpable in that it delayed for two and a half months, an urgent appointment that was sought by a clinician who directly dealt with Mr A, the patient.*
- *The clinical standard of monitoring was below that reasonably expected of the profession. There was poor self-briefing and insufficient reading by some ophthalmologists of Mr A's case notes so that a proper clinical history could be obtained of the condition and proposed management and treatment of his left eye.*
- *There was poor communication between the clinicians who dealt with Mr A, in the form of inadequate clinical notes and lack of relevant clinical detail in the clinical notes. This was evident at the appointment with Dr B on 31 August 2000. Dr B asked Mr A about the rate of spread of the cancer over the last few months, and this should have been documented in his clinical notes.*
- *There was insufficient communication between clinicians and administrative staff. This was evidenced when Mr A asked Dr B during the appointment on 31 August 2000 why the so-called "urgent, as soon as possible" appointment sought by another ophthalmologist, was delayed until mid-July 2000 then subsequently postponed until 31 August 2000. Dr B was unable to advise Mr A why the delays had occurred.*

The complaint was received on 11 September 2000 and an investigation was commenced on 4 December 2000.

Information reviewed

- Complaint information received from Mr A
- Response to complaint by Dr B and the Eye Clinic
- Mr A's clinical records from the Eye Clinic

Information gathered during investigation

Background
In 1989 Mr A was diagnosed with squamous cell carcinoma of the left eye (carcinoma-in-situ). At the time, Mr A was a private patient of ophthalmologist Dr C. In 1989 Dr C performed a surgical excision (surgical removal) of a carcinoma-in-situ of Mr A's left eye. Following this surgery, the carcinoma recurred and Mr A underwent further excisions almost every year until 1996. Sometime in 1996 Mr A felt that his eye needed more urgent attention. After unsuccessfully seeking an earlier appointment than the one that had previously been scheduled with Dr C (for a regular check-up), Mr A decided to consult another ophthalmologist for a second opinion.

Dr B – management
On 3 February 1997, Mr A consulted Dr B, ophthalmologist, at his private rooms for a second opinion about his condition. At the consultation, Mr A advised Dr B that for the last year or so he had been aware of deteriorating vision in his left eye, and over the last few months, he had experienced marked deterioration in vision and ghosting of images. Mr A also advised Dr B that his left eye had become sore, red, gritty and sensitive to light over this period. On examination Dr B noted that the left eye showed probable recurrence of carcinoma, this time involving almost the entire periphery of the cornea. Dr B proposed further excision of abnormal tissue, to which Mr A agreed.

On 3 February 1997 Dr B wrote to the Surgical Bookings Clerk at the Eye Clinic and requested that a space be found on his operating list over the next two to three weeks, for Mr A to have excision of the carcinoma.

From this initial consultation with Dr B, Mr A believed that the first stage of treatment and management of his condition would be the removal of the cancer by successive procedures, with a very good chance of success.

Surgical excision of abnormal tissue
On 5 March 1997 Dr B performed complete surgical excision of the left limbal epithelial stem cells of Mr A's left eye where the carcinoma was located. The limbal epithelial stem cells are located where the conjunctiva joins on to the cornea. Frozen sections carried out at the time on excised tissue showed no residual tumour cells. Dr B hoped the surgery would be successful in eradicating the carcinoma from the ocular surface of Mr A's left eye. At this stage, Dr B foresaw problems with ocular healing in the long term, because Mr A had large limbal defects and virtually no limbus left in his left eye as a result of the excision surgery. Dr B advised Mr A that he might require stem cell grafting (transfer of healthy tissue) from his right to his left eye at some stage in the future to maintain a healthy ocular surface. Dr B arranged regular reviews and check-ups for Mr A while his eye healed.

Follow-up and monitoring of condition
Dr B advised me that after the surgery he performed on 5 March 1997, follow-up of Mr A's left eye was ongoing and careful, with the specific intention of excluding recurrence of carcinoma. Dr B noted that his normal practice after excision of carcinoma-in-situ is to review the patient six monthly until he or she is free of tumour for two years.

Set out below is a summary review of the follow-up care that Mr A received under Dr B's care.

On 2 April 1997 Dr D, ophthalmic registrar to Dr B, reviewed Mr A at Dr B's eye clinic. Dr D noted that Mr A's eye had settled down after the surgery and was healing well and quite quickly. Dr D arranged for Mr A to be reviewed again in one week's time.

On 3 April 1997 Dr B reviewed Mr A in his eye clinic. Dr B was pleased and surprised at the speed with which the ocular surface of Mr A's eye had recovered. Dr B noted that there was no evidence of recurrence of carcinoma at this early stage and that he would follow Mr A closely over the next one to two years to make sure it did not recur.

On 24 April 1997 Dr B reviewed Mr A again in his eye clinic, and again noted there was no recurrence of carcinoma.

On 26 June 1997 a further review was conducted by Dr B which noted light sensitivity and inflammation. Furthermore, a suspicious lesion of the left and right eye was identified.

On 15 July 1997 Dr E, ophthalmic registrar to Dr B, reviewed Mr A in Dr B's eye clinic. Dr E considered the suspicious area in both Mr A's left and right eye, previously identified by Dr B, was suggestive of dysplasia (abnormal cells) and/or recurrence of carcinoma-in-situ. Dr E excised the abnormal cells on 16 July 1997. The histology report showed no evidence of malignancy.

On 25 July 1997 Dr B again reviewed Mr A and noted that he was comfortable and that his eyes were healing well.

From July 1997 to June 1998 Mr A made regular clinic visits approximately every three months as an outpatient to Dr B's eye clinic to check for recurrence of ocular surface carcinoma.

During this period Mr A had symptoms of blurred vision and ocular irritation. Dr B advised me that these symptoms were, in his opinion, caused by the complete excision of the left limbal epithelial stem cells on 5 March 1997. He also noted that biopsies taken on 16 July 1997 had shown no evidence of malignancy. Dr B advised that the negative biopsy result, together with the long period of non-recurrence of carcinoma, indicated that the tumour was indeed removed.

On 19 January 1998, Dr B noted that although Mr A had significant scarring to the periphery of the cornea from previous surgical excisions, there was no sign of recurrence of the carcinoma in his left eye. Dr B continued to review Mr A every three months to ensure that no recurrence developed.

On 19 June 1998 Dr B conducted a routine examination of Mr A and observed symptoms of recurrence of carcinoma, although there was no clear source of the carcinoma, because of the previous limbal excision conducted in 1997.

Second opinion

On 23 June 1998 Dr B wrote to Dr F, an ophthalmic colleague with external eye expertise, seeking a second opinion. Dr B advised Dr F of the limbal surgical excisions he performed on Mr A's left eye in March 1997, and of the excisions that were performed in July 1997 by Dr E. Dr B noted that since then, there had been no sign of recurrence of carcinoma, but he was suspicious of some changes that had recently occurred in Mr A's left eye. Dr B advised Dr F that Mr A's left eye now presented with a "diffuse greyish epithelium covering most of the cornea" and that he was "suspicious this may represent extensive recurrence of carcinoma". Dr B noted that there was no obvious limbal source for the abnormal tissue due to the near total limbal conjunctiva excision he performed in March 1997. Dr B sought Dr F's opinion about the matter and whether he:

- agreed that the diffuse greyish epithelium covering most of the cornea was recurrence of carcinoma;
- would do a limbal stem cell autograft after excision; or
- thought that an amniotic membrane might have anything to offer.

Limbal stem cell autograft is a surgical operation involving the transfer of healthy tissue from the limbal stem cells of the healthy eye to the diseased eye. In Mr A's case, Dr B advised that this procedure would have involved taking tissue from Mr A's healthy right eye and grafting it onto his diseased left eye, with some risk of damage to the sight of the right eye.

On 26 August 1998 Mr A saw Dr F. Mr A had previously been briefed by Dr B about the reasons for seeking a second opinion from Dr F. Mr A was in agreement with this course of action. On 1 September 1998 Dr F advised Dr B, in writing, of his findings from Mr A's visit. Dr F confirmed to Dr B that Mr A had 360° of superficial vascularisation and opacification of his left cornea. Mr A's left cornea was becoming non-transparent and unable to transmit light effectively because the remaining healthy corneal epithelium in his left eye was rapidly being replaced by the surrounding conjunctival epithelium. Dr F noted that staining tests indicated lack of recurrence of carcinoma in Mr A's left eye. Dr F confirmed shortening of all of the left conjunctival fornices of Mr A's left eye. Dr F noted that examination of Mr A's right eye confirmed no significant ocular pathology.

Dr F discussed the above findings with Mr A. Mr A recalled that Dr F explained to him that the course of treatment would be to let the eye recover at its own rate, with regular follow-up monitoring. However, irritation and inflammation in his left eye made Mr A believe that his left eye was not recovering normally. Mr A wondered if too much healthy tissue had been removed during previous excisions for an effective recovery and healing process to occur. Mr A recalled that despite deteriorating vision in his left eye, he was told that this, as well as his other symptoms, was due to scar tissue from previous excisions spreading over the cornea. Mr A recalled that he was told there was no cancer present in his left eye.

Dr F recommended the following management plan to Dr B for Mr A:

- to first address the significant ocular surface inflammation of Mr A's left eye by placing him on a course of oral doxycycline to help control the inflammation;

- to recommend preservative free topical steroids, methylprednisone 1% drops three times daily to the left eye, only to also assist in controlling the inflammation; and
- that Mr A should continue the use of preservative free artificial tear drops.

Dr F advised Dr B that once the ocular surface inflammation had settled and been under control for six weeks, he would suggest discussing the role of limbal stem cell autograft as being the best way of improving Mr A's left ocular surface. Dr F noted that this procedure had an extremely low risk to Mr A's otherwise healthy right eye, and would be by far the best way of improving the vision in his left eye, and improving his photophobia and comfort.

Dr F advised Dr B that amniotic membrane transplantation had little to offer in relation to autograft, as the primary role of the amniotic membrane is to reduce inflammation and reduce the risk of autograft rejection. After the consultation, Dr F referred Mr A back to Dr B for ongoing care.

Stem cell autograft – transferral of tissue
Mr A recalled being advised of a mid-term option of restoring his left eye to good health, by transferring healthy tissue from the right eye to the left (stem cell autograft), with a very good chance of success and with only a slight chance of harm to the right eye. Mr A maintains that he was never offered this as an immediate option and that stem cell autograft was only ever discussed as an option to consider in the future. Mr A advised that he would certainly have asked detailed questions about the procedure, if it had been presented to him as an alternative. He would have questioned the amount of tissue that would be transferred from his right eye; how his left eye would be prepared for the transfer of tissue; what the limitations on his mobility (if any) would be; what risks would be involved, and so on.

Dr B advised that the option of transferring tissue from Mr A's right to his left eye was discussed with him on multiple occasions. The medical records show that Dr B, in his letter of 25 March 1997 to Dr C, states that he has warned Mr A that he may require stem cell grafting from his right eye at some stage in the future, to maintain a healthy ocular surface. Dr F advised, in his letter of 1 September 1998 to Dr B, that in his opinion, once the ocular surface inflammation had settled, he would suggest "again" discussing the role of limbal stem cell autograft as being the best way of improving Mr A's left ocular surface. Dr B also advised that it should be noted there are risks to the health of the donor eye associated with this surgery, and that this treatment would not be expected to influence the chance of recurrence of the carcinoma.

Mr A was next reviewed at Dr B's eye clinic on 1 October 1998, following the second opinion by Dr F. The medical record for this visit documents that Mr A's left eye had improved to a large degree and that his vision was much better. On examination, it was noted that the left eye was less inflamed and that there was still a small amount of healthy corneal epithelium remaining in the left eye. The medical records for this visit state that if his left eye deteriorated further it would need a limbal transplant (stem cell autograft). It is not clear from the information provided whether or not this was actually discussed with Mr A during this consultation.

Mr A's next review at Dr B's eye clinic was on 10 December 1998. Mr A's condition remained the same as on the previous visit, although a change of spectacles was recommended. The medical record for this visit documents this and notes that Mr A was warned that he might need to change the spectacles again if his vision deteriorated further.

Mr A was reviewed again in Dr B's eye clinic on 1 April 1999. The medical record for this visit notes that Mr A's left eye was chronically sensitive with stable conjunctival overgrowth and no recurrence of carcinoma.

Mr A wrote to Dr B on 25 June 1999 and advised:

> "After several weeks of much improved vision in my left eye following use of my new glasses, I am now aware of a definitive cloudiness of vision which seems to be gradually increasing.
>
> I have been continuing using the DOXY 100 Tablets (1 per day) with the non preservative eye drops (3 per day) first prescribed by [Dr F]. This has been quite a long-term use, and I wonder if it could be reviewed."

In response to Mr A's letter, a review appointment was scheduled for him at Dr B's eye clinic for 19 August 1999. At this appointment, it was noted in the medical record that Mr A had foggy vision in the left eye and possible extension of conjunctival growth over the cornea of the left eye. A further appointment was scheduled for Mr A on 25 November 1999.

On 25 November 1999 Dr G, ophthalmic registrar to Dr B, reviewed Mr A at Dr B's eye clinic. Dr B advised me that at this stage, Mr A's left eye had a vascularized, conjunctival covered cornea but no recurrence of carcinoma. Dr B noted that the possibility of stem cell autograft was also discussed with Mr A at this visit and Mr A declined the surgery. This matter is documented in the medical record as: "Offered option of stem cell autograft – not keen at present."

Mr A's next review in Dr B's eye clinic was on 16 March 2000 with Dr H, ophthalmic registrar to Dr B. At this visit, Dr B advised that Mr A's cornea remained unchanged from his last visit and that the options of stem cell autograft or leaving the eye alone were discussed. Dr B noted that Mr A declined the option of surgery. The medical record for this visit states:

"Options < leave / stemcell autograft
discussed, agrees leave for now."

Request for appointment
As the vision in his eye continued to deteriorate, with increasing discomfort, on or about 11 June 2000 Mr A telephoned the Eye Clinic for the earliest possible appointment. Mr A says he was told he could not change the date of an already scheduled appointment for 20 July 2000, as there was no possibility of being seen at an earlier date. Mr A then telephoned the Eye Clinic again a day or so later and was told that he could come in if he felt it was urgent.

Professor I, Clinical Director of Ophthalmology, stated that at present, if patients do wish to have a more urgent appointment, the matter can be discussed with a nurse at the Clinic and the nurse then ascertains whether an urgent appointment is required and appropriate in the particular circumstances. However, for an urgent appointment, patients generally need to contact their general practitioner, who then contacts the medical staff at the Eye Clinic to discuss the situation.

On 13 June 2000 Mr A presented acutely to the Eye Clinic with a sore watery sticky left eye. Dr J, ophthalmic registrar, reviewed Mr A. On examination Dr J noted that Mr A's left eye had severe ocular surface disease consistent with limbal stem cell deficiency and a suspicion of recurrent squamous cell carcinoma on the cornea. Dr J recorded in the medical record for 13 June 2000 that Mr A should "avoid topical steroids at present. Review pls [please] in [Dr B's] Clinic in 2–4 wks." Dr J signed this entry in the medical record.

Mr A recalled that Dr J examined his eye and said that he would make an urgent follow-up appointment "as soon as possible". However, Dr J did not state the words "urgent" or "as soon as possible" in the medical record. Mr A advised that until Dr J told him of recurrence of cancer in his left eye, ophthalmologists had consistently given him the impression that treatment up to then had been successful and that his left eye had been free of cancer for two years.

Recurrence of carcinoma / removal of eye
Dr B advised me that when he reviewed Mr A in his clinic on 31 August 2000, he discussed the possible necessity for removal of his left eye because of the widespread nature of the cancer.

Mr A maintains this was the first time he had ever heard the tissue that had been visibly spreading over his left eye, described as cancer. Mr A was "astounded and shocked" when Dr B told him that the cancer was now so widespread that the eye was beyond treatment, and that there was also a small chance of the cancer having spread beyond the eye. Mr A states that up until this appointment, he thought the tissue that had spread over his left eye was scar tissue, and was under the impression that any cancer in his left eye was still limited to a tiny manageable area in the scar tissue, with insignificant health consequences.

Mr A says that ophthalmologists had previously told him that removal of his left eye would be necessary only if the other options of surgical excision and stem cell autograft failed to prevent the spread of the cancer beyond the eye. Mr A maintains that removal of the eye was presented to him as a distant option that would safeguard his long-term health.

Dr B maintains that the possibility and actual occurrence of recurring cancer had been discussed with Mr A on multiple occasions in the past, as part of his ongoing care. The recurrence of carcinoma was not an unexpected event, which is why regular follow-up checks of Mr A's left eye were carried out.

Professor I advised me that the delay experienced by Mr A may or may not have contributed to the severity of his condition, but it probably did not alter the management options for him. The relatively sudden widespread recurrence of carcinoma would almost certainly have led to the removal of Mr A's left eye, irrespective of whether he had been seen four or 10 weeks after his consultation with Dr J on 13 June 2000.

Surgical removal of left eye

On 11 September 2000 Mr A attended a clinical case conference in relation to the pending surgery for the removal of his left eye. Mr A recalled that about 12 ophthalmologists briefly examined his eye in turn, mostly on their own, but sometimes in pairs. Mr A asked two of the ophthalmologists whether the kind of cancer in his left eye was known to recur rapidly, and both confirmed that was the case. Mr A therefore believes the matter should have been taken into account in the follow-up monitoring.

Dr K, the oculoplastic surgeon / ophthalmologist who was to perform the surgical removal of Mr A's left eye, discussed the matter with Mr A at the case conference. At 7.20pm that evening Mr A recalled that he received a telephone call from one of the ophthalmologists who attended the case conference, confirming the decision to remove the left eye and that the surgery was set for 21 September. Mr A recalled being "pleased at the short waiting time". However, at 7.20pm on 20 September, the evening before the planned surgery date, Dr K telephoned Mr A and advised him that there were no recent biopsy samples showing the cancer in his eye, and he wanted to establish the extent of the cancer before removing the eye. Mr A recalled that Dr K told him that, instead of removing his eye the next day, he would "do a few tiny biopsies around and including the tumour". Mr A was surprised at what Dr K told him and wondered why the biopsy results from previous excision surgeries were not available for review.

Before the biopsy sampling on 21 September 2000, Mr A recalled Dr K apologising to him for the change in plan. The biopsy results received on 26 September 2000 confirmed the recurrence of carcinoma-in-situ of the left eye. Dr K and Professor I reviewed the results. Both agreed that the left eye and orbit needed to be removed. On 28 September 2000 Dr K performed left orbital exenteration (surgical removal of the left eye and orbit). Mr A was discharged from hospital on 30 September 2000.

Complaint

Mr A maintains that too much time elapsed between follow-up appointments and that follow-up monitoring was not adequate or effective, and that this was the major causal

factor leading to the removal of his left eye. Furthermore, Mr A maintains that the Ophthalmology Department's administrative system did not respond as it should have to the urgency he expressed about his left eye. Mr A believes that the system is culpable, as it did not mark his previously scheduled appointment for 20 July as "urgent" after he saw Dr J on 13 June 2000 and after his further discussions with staff.

Documentation in the clinical notes
Mr A maintains that there was poor communication between the clinicians who dealt with him, in the form of inadequate clinical notes and lack of relevant detail in the clinical notes. This was evident at his appointment with Dr B on 31 August 2000 when Dr B asked him about the rate of spread of the cancer in his left eye over the last few months, something Mr A thought should have been documented in his clinical notes.

Dr B advised me that he asked Mr A about the matter so as to determine the course of the disease over this period from Mr A's perspective, not because the clinical notes lacked sufficient detail.

Communication between clinicians and administrative staff
Mr A believes that there was insufficient communication between clinicians and administrative staff at the Eye Clinic. After seeing Dr J on 13 June, he thought he would be reviewed in two to four weeks. Mr A was surprised and disappointed when he received a letter from the Eye Clinic dated 13 June informing him that he would be reviewed on 20 July. Mr A telephoned the Eye Clinic and asked if the appointment could be changed to an earlier date. Mr A was told: "No, but we will see what we can do." Shortly after this, Mr A received another letter dated 22 June, informing him that his next appointment would be on 20 July, the same date as previously advised. Mr A was dismayed to receive another letter postponing his appointment for 20 July until 31 August. Mr A felt angry and insulted that his interests as a patient were being subjected to such arbitrariness and, accordingly, he telephoned the Eye Clinic to see if there had been some mistake. Mr A was told that he could not have an earlier appointment. Mr A then telephoned the Eye Clinic again and spoke to Dr B's secretary, who advised him that nothing could be done for an earlier appointment. Mr A requested that he be fitted in to any cancellation and stressed that he was very concerned about the condition of his eye and the delay that had occurred with what he understood to have been an "urgent, as soon as possible" appointment. Mr A heard nothing more about the matter.

Mr A saw Dr B on 31 August and asked him why the so-called "urgent, as soon as possible" appointment that he thought Dr J requested on 13 June, was delayed until 20 July then subsequently postponed until that day (31 August).

Dr B advised me that he is unable to comment on why there was a delay between when Dr J saw Mr A on 13 June 2000, and when he saw Mr A in his clinic on 31 August 2000.

Professor I, the Clinical Director of the Ophthalmology Department, stated that it is not unreasonable that Dr B had no immediate knowledge of why one particular patient's previously booked appointment had been rescheduled. Professor I noted that the Eye Clinic sees 45,000 patients per year and that many of them are rescheduled, often after

consultation with the doctor concerned. Professor I noted that in June 2000, 1380 new patients and 2399 follow-up patients were seen at the Eye Clinic; in July 2000, 1222 new patients and 2157 follow-up patients were seen; in August 2000, 1265 new patients and 2323 follow-up patients were seen. Professor I noted that there are 10.68 full-time equivalent ophthalmologists and six registrars in training employed in the Eye Clinic to review all of these patients.

Professor I found on checking the clinical booking system that the emergency (urgent) booking requested by Dr J for Mr A was not made because, prior to his acute presentation at the Eye Clinic on 13 June 2000, an appointment had already been scheduled for Mr A to be reviewed in the Eye Clinic on 20 July 2000. The appointment scheduled for 20 July was a routine follow-up appointment that had originally been booked prior to 13 June, and therefore prior to Dr J's diagnosis (not confirmed) of ocular tumour recurrence, so it was not marked as "urgent". Professor I noted that although this routine appointment was actually scheduled for five weeks after Mr A saw Dr J on 13 June, the difference between four and five weeks would be immaterial as most appointments have a latitude of one to two weeks.

Professor I advised that it is not clear why the 20 July routine follow-up appointment was not subsequently marked as "urgent". Professor I noted that it may be that when the booking clerk checked on the database and saw that Mr A already had a routine follow-up appointment scheduled for 20 July, he or she left it at that without marking "urgent" on the appointment. Professor I noted that the word "urgent" was not recorded in the clinical notes that were entered and signed by Dr J.

Professor I stated that it is unfortunate that Mr A's scheduled appointment for 20 July was subsequently cancelled and rebooked for six weeks later. Professor I noted that the cancellation probably occurred because of overbooking. The Eye Clinic sees approximately 45,000 patients per year and is often overbooked, resulting in urgent cases taking priority. Professor I noted that because Mr A's appointment was not marked "urgent", it may have been delayed for a further six weeks to accommodate what appeared to be more urgent cases. After making enquiries about the cancellation, Professor I has not been able to ascertain a definitive reason for it.

Dr B commented that the delay that occurred between when Dr J saw Mr A on 13 June and when he reviewed him on 31 August may or may not have contributed to the severity of spread of the tumour before further surgical treatment could be undertaken.

Review of booking system

Professor I advised me that the Eye Clinic is currently examining the issue of highlighting urgent cases. Professor I discussed the issue with the Nurse Manager of the Eye Clinic. The matter was also raised and acknowledged at a meeting with the Retinal Service as a difficulty across ophthalmic referrals.

Independent advice to Commissioner

The following expert advice was obtained from an independent ophthalmologist, Professor R S Clemett:

"Thank you for asking me to provide an independent professional opinion on the standard of care and service received by [Mr A] from [Dr B] and the other ophthalmologists of the [public hospital's] Eye Department.

Summary of the clinical condition

The clinical condition is well documented both in the clinical records and the letter of [Dr B] appended. This patient had a chronic ocular problem due to multifocal carcinoma-in-situ, limbal stem cell deficiency as a consequence of the carcinoma-in-situ and excision of these neoplastic lesions, rosacea and the sequelae of multiple surgical procedures on the cornea and conjunctiva.

Specific complaints

- [Mr A] advises that he had a series of surgical treatments over several years and was informed that the cancer had been removed. [Mr A] subsequently found out that this was not the case.

Carcinoma-in-situ can be a multifocal disease. Although the lesions excised by several ophthalmologists may have resulted in removal of the immediate problem, recurrent disease can occur elsewhere around the corneal limbus at intervals after the initial problem. [Mr A] does not appear to have been made aware of the potential for the problem to occur at other sites on the ocular surface.

- [Mr A] advises that he visited the acute clinic on 13.6.00 and was advised by an […] ophthalmologist who examined his left eye that he would require an urgent follow-up appointment. This appointment was set for four weeks' time and subsequently postponed a further six weeks.

[Professor I] has set out the reasons why this occurred. I seriously doubt that the delay of six weeks had a detrimental effect on this patient's tumour. Certainly the tumour could not extend around the circumference of his cornea in six weeks and would generally only show 1-2mm of growth over that interval. It is my opinion that this patient had multifocal carcinoma-in-situ for some time but its presence was difficult to detect because of the limbal stem cell deficiency, conjunctivalisation of his cornea and vascularisation. Conjunctival carcinoma-in-situ typically has a discrete edge corresponding to the abrupt transition from dysplastic to normal epithelium. However, a less commonly encountered variety has ill-defined edges and is more difficult to diagnose and excise because distinct tumour edge is not recognised clinically. This variety of carcinoma-in-situ is associated with chronic vascular congestion and is easily mistaken for other causes of chronic red eye such as limbal stem cell deficiency. I am uncertain as to the exact type of carcinoma-in-situ clinically present in this patient;

however, the limbal stem cell deficiency, rosacea and surgery would make the clinical diagnosis of recurrent disease more difficult. Also the two doctors seeing the patient prior to [Dr B] were junior staff members who would be less able to detect the presence of carcinoma-in-situ in difficult circumstances.

- On 31.8.00 [Dr B] told [Mr A] that this left eye had extensive recurrence of squamous cell carcinoma and that the lesion was no longer carcinoma-in-situ. The patient was offered the option of enucleation.

Carcinoma-in-situ at some stage may become squamous cell carcinoma. The transition between the two is the extent of invasion of the neoplastic cells. Squamous cell carcinoma is usually thicker and may form an exophytic nodule or sheet. It is recorded in the notes that this patient required documentation by histology to confirm the presence of a squamous cell carcinoma before proceeding to exenteration. I suspect that the 31.8.00 was the first occasion when [Dr B] suspected that the patient had clinical squamous cell carcinoma rather than the sequelae of the limbal stem cell deficiency and previous surgical procedures.

- [Mr A] is concerned that he was not offered the option of restoring his left eye to good health by transferring tissue from his right eye to his left eye.

This is incorrect. There are three clinical records indicating that he was indeed, offered this option and declined, ie November 1999 ([Dr E]), 16 March 2000 ([Dr H]) and [Dr B] also makes mention that [Mr A] was offered the option of a homograft from the other eye. While a homograft may have improved the status of his limbal stem cell deficiency, it would not have prevented him from developing further carcinoma-in-situ or squamous cell carcinoma.

- [Mr A] is concerned that if previous surgical treatment had left his eye free of cancer for two years, why had subsequent management not kept his eye free of cancer.

The tumour in this patient was multifocal and the clinical recognition of its presence was impeded by previous surgery, limbal stem cell deficiency and rosacea.

- [Mr A] alleges that he was not followed sufficiently frequently in the clinic.

This patient was seen at approximately 3-monthly intervals which is an appropriate clinical interval. I cannot support his contention that this was a major causal factor in the final outcome of why his left eye had to be removed. Frequently patients who have been treated for carcinoma-in-situ are followed at 6-monthly intervals and discharged after two years if free of disease.

- [Mr A] alleges that the Ophthalmology Department's administrative system did not respond as it should to the urgency expressed by him of his condition.

While ideally every patient with neoplasia should be treated as soon as possible after diagnosis, restraints on staff and resources make this an impossible goal. It is my opinion that [Mr A's] clinical management was not impeded substantially by delay in him being seen in the outpatient clinic. This however, does not mean that I support the concept that there is no degree of urgency for neoplastic cases. It would have been much more satisfactory for [Mr A] to be seen as soon as possible after diagnosis. An unfortunate administrative hiccup impeded his being seen at four weeks. I am sure that [Professor I] has taken note of this process issue and will address it.

- [Mr A] alleges that the clinical standard of monitoring was below that reasonably expected of the profession.

I have read the clinical records and find entries have been made by multiple staff in an outpatient setting. The clinical notes record the chronic and progressive nature of his condition. I am unable to comment on whether there was poor self briefing or insufficient reading by some ophthalmologists of his case notes.

- [Mr A] alleges there was poor communication between clinicians who dealt with him and inadequate clinical case notes.

I acknowledge that the case notes appear brief in part but there are often detailed clinical drawings of the appearance of his cornea. If a detailed clinical note was made on each outpatient attendance, significantly fewer patients would be seen in such a busy clinic and the delay for patient consultations would be even longer.

Additional opinions

1. What are the specific standards that apply and were these followed by the ophthalmologists who treated [Mr A]?

The ophthalmologists were carrying out routine outpatient assessments for management and treatment of a chronic corneal and conjunctival problem in this patient which was complicated by preceding surgery, limbal stem cell deficiency and rosacea. The standard of care could be improved by detailed corneal drawings of the clinical features present on each occasion. Standardisation of the corneal drawings would have been an advantage. While this would have facilitated the transfer of information from clinician to clinician, I seriously doubt whether it would have had a significant impact on the management or outcome of this patient's clinical condition.

2. From that information provided, was the Department's monitoring process ineffectual or of insufficient frequency or quality as alleged by [Mr A]?

It is my opinion that this patient was monitored carefully and that the inherent nature of his condition was the reason for his multifocal lesions at recurrences and eventual loss of his eye. I do not believe that the frequency of the follow-up appointments should have been increased.

It is impossible to comment on the communication that took place between the ophthalmologist and patient. It seems to me that the patient may not have been fully aware of the potential for recurrent or new lesions to occur in his left eye and of the difficulty that can be encountered in detecting recurrent carcinoma-in-situ or even squamous cell carcinoma. Even in a busy outpatient setting within the public hospital I would expect good communication to occur and for the patient to be made fully aware of the potential problems from his ocular condition. I am uncertain how the news that this patient required enucleation was passed to the patient, but it seems from the patient's response that he may not have been sympathetically made aware of his problem. Communication with patients is a critical factor for maintaining good rapport, patient co-operation and compliance."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Consumer Services' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

…

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

(a) An explanation of his or her condition;

(b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Opinion: No breach

In my opinion Dr B and the Eye Clinic at the public hospital did not breach Right 4(1), Right 4(5), Right 6(1)(a) or Right 6(1)(b) of the Code of Health and Disability Services Consumers' Rights (the Code) for the reasons set out below.

Right 4(1)

Follow-up care / monitoring of condition
Mr A was concerned why, if previous surgical treatment/excisions had left his eye free of cancer for two years, the subsequent management and follow-up care did not keep his eye free of cancer. He alleged that too long a period of time was allowed between monitoring appointments and that this was a major causal factor leading to the removal of his left eye.

Mr A first saw Dr B on 3 February 1997 for a second opinion of his condition. I note that Mr A received surgery promptly afterwards, on 5 March 1997. Dr B performed a complete surgical excision of the left limbal epithelial stem cells of Mr A's left eye, where a carcinoma was located.

Immediately after surgery Mr A was reviewed weekly. Subsequently, Mr A received appointments at approximately three-monthly intervals. He was also referred for a second opinion, and received further surgery from Dr E. He attended the following appointments at the Eye Clinic:

- Following the surgery of 5 March 1997 Mr A attended Dr B on 7, 13, 20, 27 March 1997.
- 2 April 1997 reviewed by Dr D.
- 3 April, 24 April, 26 June 1997 reviewed by Dr B.
- 16 July 1997 further surgery by Dr E to excise abnormal cells.
- 25 July, 29 August, 26 September, 19 December 1997 reviewed by Dr B.
- 20 March, 19 June 1998 reviewed by Dr B.
- 26 August 1998 second opinion by Dr F.
- 1 October and 10 December 1999 reviewed by Dr B.
- 1 April, 19 August 1999 reviewed by Dr B.
- 25 November 1999 reviewed by Dr G.
- 16 March 2000 reviewed by Dr H.
- 13 June 2000 reviewed by Dr J (Dr J requested review in Dr B's clinic in 2-4 weeks).
- 31 August 2000 consultation with Dr B. At this appointment, Mr A was advised that cancer so widespread that removal of eye was advisable.

Dr B comments:

> "After the surgery, follow-up was ongoing and careful with the specific intention of excluding recurrence. Additional steps including a second opinion from a colleague with external eye disease expertise ([Dr F]) and biopsy of suspicious ocular surface changes were taken."

My advisor's opinion is that Mr A was monitored carefully and that the inherent nature of his condition was the reason for the recurrences and the loss of his eye. My advisor does not consider that the frequency of the follow-up appointments should have been increased. He commented that frequently, patients who have been treated for carcinoma-in-situ are followed at six-monthly intervals and discharged after two years if free of disease.

I am guided by the independent advice I received. Based on my advisor's advice, and the facts as set out above, the allegation that "too long a period of time was allowed between monitoring appointments" is not substantiated. I am satisfied that Mr A's reviews at the Eye Clinic were regular, timely and ongoing. There is no evidence to suggest that the management and follow-up contributed to the loss of Mr A's eye. As my advisor noted: "I cannot support his [Mr A's] contention that this was a major causal factor in the final outcome of why his left eye had to be removed."

In my opinion Dr B and the Ophthalmology Department of the public hospital provided adequate monitoring and follow-up care to Mr A for his condition and did not breach Right 4(1) of the Code in this regard.

Clinical standard of monitoring

Mr A considers that the clinical standard of monitoring was ineffective and fell below that reasonably to be expected of an ophthalmologist. In particular, he considers that there was poor self-briefing and insufficient reading of his case notes by the various different ophthalmologists who saw him. He considers this to be evidenced by comments made by some ophthalmologists during follow-up visits. Mr A believes the lack of proper clinical knowledge of his case history contributed to the failure to detect the recurrence of his cancer.

I note that, prior to consulting Dr B in February 1997, Mr A had undergone surgical excision of carcinoma in 1989 by Dr C. After this, there was further recurrence of carcinoma in Mr A's left eye with further excisions almost every year until 1996, and then again in March and July 1997. After a period free of recurrence, the carcinoma recurred.

There is no specific evidence to verify whether there was poor self-briefing or insufficient reading by different ophthalmologists of Mr A's case notes. However, in the circumstances of Mr A's case history, I find it more likely than not that the ophthalmologists read the case notes before seeing him, and were alert for signs of recurring carcinoma.

Significantly, there is no evidence to suggest that Mr A's eye carcinoma should have been diagnosed earlier. I note my advisor's comments that the tumour in Mr A's left eye was multifocal, and the clinical recognition of its presence was difficult and was in fact impeded by previous surgery, limbal stem cell deficiency and rosacea. There is also no evidence to suggest the management of Mr A's condition was not appropriate in the circumstances.

Accordingly, in my opinion Dr B and the Ophthalmology Department of the public hospital provided an appropriate standard of clinical monitoring to Mr A and did not breach Right 4(1) of the Code in this regard.

Right 4(5)

Under Right 4(5) of the Code every consumer has the right to co-operation between providers to ensure quality and continuity of care. Mr A was concerned that, because of inadequate clinical notes, there was poor communication between the clinicians who treated him.

Standard of clinical case notes
Mr A was concerned that the clinical notes do not accurately state or reflect matters that were discussed with him by various ophthalmologists at consultations. This resulted in the different ophthalmologists involved in his care having an incomplete knowledge of his case history, which handicapped their ability to appropriately manage and diagnose his condition.

Dr B refutes the allegation that the clinical standard of monitoring of Mr A's condition was below professional standards. Dr B maintains that the clinical history and clinical detail are adequately recorded in the notes.

My advisor acknowledged that although the clinical case notes appear brief in part, there are often detailed clinical drawings of the appearance of Mr A's cornea in the case notes. He noted that the ophthalmologists were carrying out routine outpatient assessments for management and treatment of a chronic corneal and conjunctival problem, which was complicated by preceding surgery, limbal stem cell deficiency and rosacea. He commented that detailed corneal drawings of the clinical features present on each occasion and standardisation of the corneal drawings would have been an advantage, and would have facilitated the transfer of information from clinician to clinician, but doubted whether it would have had a significant impact on the management or outcome of Mr A's clinical condition.

I note that Mr A was particularly concerned that Dr B asked *him* to describe the rate of the spread of his cancer on 31 August 2000, as this was not detailed in the notes. Dr B has commented that he asked Mr A to describe the rate of the spread of the cancer over the last few months in an attempt to determine the course of the disease from Mr A's perspective. While his comments may have given Mr A the impression that Dr B was not able to gain an adequate understanding of his condition by consulting the written material, I am not persuaded that this was actually the case.

I note my advisor's comments that regular standardized corneal illustrations may have been of assistance in facilitating the description of Mr A's condition. Although the standard of drawing would ideally have been higher, it appears from my advisors' comments that the medical notes were of an adequate standard in the circumstances. In my opinion, the clinical records and entries made by multiple ophthalmic staff in an outpatient setting appropriately record the chronic and progressive nature of Mr A's condition.

I am guided by the independent advice I received. Based on my advisor's advice, and all the surrounding circumstances, in my opinion Dr B and the Ophthalmology Department of the public hospital did not breach Right 4(5) of the Code in relation to the standard of Mr A's clinical case notes.

Right 6(1)(a)

Under Right 6(1)(a) every consumer has the right to an explanation of his or her condition. This explanation includes the information that a reasonable consumer, in that consumer's circumstances, would expect to receive.

Mr A alleged that Dr B failed to explain his condition because his appointment of 31 August 2000 was the first time that he had ever heard the tissue that had been visibly spreading over his left eye, described as cancer. Mr A was "astounded and shocked" when Dr B told him that the cancer was now so widespread that the eye was beyond treatment. Up until this appointment, Mr A thought the tissue that had spread over his left eye was scar tissue, and that any cancer in his left eye was still limited to a tiny manageable area in the scar tissue, with insignificant health consequences for himself.

The clinical records show that it was not confirmed that Mr A's cancer had recurred until the appointment on 31 August, although Dr J observed a markedly abnormal epithelium on 13 June and was suspicious of a recurrence. In view of these findings, Dr J requested an urgent follow-up appointment.

It was only on 31 August that it became apparent to Dr B that the lesion was suspicious of cancer and had progressed from carcinoma-in-situ into squamous cell carcinoma. This was confirmed by histology report. My advisor notes that this was probably the first occasion when Dr B suspected that the patient had clinical squamous cell carcinoma, rather than the sequelae of the limbal cell deficiency and previous surgical procedures.

It is evident that Mr A was not fully aware of the potential for recurrent lesions to occur or of the difficulty that can be encountered in detecting recurrent carcinoma-in-situ or squamous cell carcinoma. I note that Mr A had ongoing recurrence of carcinoma since he was first diagnosed in 1989 by Dr C. Mr A had experienced recurrence of cancer and further excisions almost every year until 1996 and had been free of cancer since then. Understandably, he had formed the view that the cancer was no longer present and was hopeful that it would not recur. Clearly, the word "cancer" was not used until the 31 August appointment, although there was cause for concern after Dr J requested an urgent appointment with Dr B.

Earlier, whilst the cancer may have begun to recur, it was not specifically noted or described as such to Mr A. As my advisor commented, if present prior to this time, it was masked by the difficult surrounding symptoms. Mr A's belief that the tissue spreading over the eye was scar tissue was not disproved until the diagnosis was confirmed, following receipt of the histology report in August 2000.

Accordingly, I do not consider that Mr A was misled about his condition by either Dr B or the other members of the Ophthalmology Department at the public hospital whom he consulted. Understandably, the proposed removal of his eye as a result of recurrence of carcinoma came as a great shock to Mr A, but I am satisfied that the consequences of his condition were explained to him as soon as the diagnosis was evident.

In light of my advisor's comments, and taking into account all the surrounding circumstances, in my opinion Dr B and the Ophthalmology Department of the public hospital did not breach Right 6(1)(a) of the Code.

Right 6(1)(b)

Tissue transferral
Under Right 6(1)(b) of the Code, Mr A had the right to an explanation from Dr B and the other ophthalmologists who treated him, of the options available for the treatment and management of the carcinoma-in-situ of his left eye. Mr A maintains that he was never offered the option of restoring his left eye to good health by transferring healthy tissue from his right eye to his left eye (homograft or stem cell autograft). Mr A maintains that it was mentioned to him only briefly as a future possibility, if necessary, and never as an immediate or urgent option.

Dr B maintains that the option was discussed with Mr A on multiple occasions. He also comments that a stem cell autograft would not have influenced the chance of recurrence of the carcinoma in Mr A's left eye and, therefore, would not have affected the outcome.

The medical record shows the option of a stem cell autograft was consistently considered by Dr B and other ophthalmologists involved in his care:

- Dr B, in his letter of 25 March 1997 to Dr C, states that he had warned Mr A that he might require stem cell grafting from his right eye at some stage in the future, to maintain a healthy ocular surface.

- Dr F advised, in his letter of 1 September 1998 to Dr B, that in his opinion, once the ocular surface inflammation had settled, he would suggest "again" discussing the role of limbal stem cell autograft as being the best way of improving Mr A's left ocular surface.

- Dr B comments in the medical notes of 1 October 1998 that "if condition worsens again then [consider] limbal transplant".

- Medical notes of 25 November 1999, by Dr G, state: "Offered option of stem cell autograft. Not keen at present."

- Medical notes of 16 March 2000, by Dr H, indicate that Mr A was offered the option of a stem cell autograft.

I acknowledge Mr A's perception that transferral of healthy tissue from his right eye to his left eye may have restored his left eye to good health and that, as a result, he considers that this option was not sufficiently explored. However, the records show that the option of a stem cell autograft was discussed with Mr A on a number of occasions, and offered to him. Mr A has said that it was discussed with him, but never actually offered as an option or fully discussed. While there is a conflict of evidence regarding the nature of discussions held around this issue, I am influenced by the number of times the medical record shows discussion of a stem cell autograft with Mr A by various providers. In these circumstances,

I am not persuaded that this option was not sufficiently explained. Furthermore, my advisor comments:

> "While a homograft may have improved the status of his limbal stem cell deficiency, it would not have prevented him from developing further carcinoma-in-situ or squamous cell carcinoma."

I am guided by the independent advice I received. Accordingly, based on my advisor's advice and all the surrounding circumstances, in my opinion Dr B and the Ophthalmology Department of the public hospital did not breach Right 6(1)(b) of the Code in this regard.

Opinion: Breach

In my opinion the Ophthalmology Department of the public hospital breached Right 4(5) of the Code for the reasons set out below.

Right 4(5)

Communication between clinicians and administrative staff
Mr A is concerned that the Ophthalmology Department's administrative system did not provide him with an urgent appointment, which was recommended by Dr J, following the consultation of 13 June 2000. Furthermore, the Ophthalmology Department failed to respond to his requests and pleas for an earlier appointment. Mr A was also concerned that Dr B was unable to tell him why the delays had occurred.

On 13 June 2000 Mr A presented acutely to the Eye Clinic with a painful, watery, sticky, left eye. Ophthalmic registrar Dr J saw Mr A. After seeing Dr J, Mr A advised that he was told that he would be given an "urgent" or "as soon as possible" appointment to be seen in Dr B's eye clinic.

The Ophthalmology Department did not provide Mr A with the recommended urgent appointment. It appears that, prior to the consultation with Dr J, a routine follow-up appointment had already been scheduled for 20 July 2000 in Dr B's eye clinic. Administrative staff did not distinguish between this routine appointment and the more urgent one requested by Dr J. Unfortunately, to make matters worse, this review appointment was subsequently delayed until 31 August 2000 because of overbooking.

On receipt of the 20 July appointment, Mr A contacted the Ophthalmology Department to request an earlier appointment. It appears that Mr A's requests for an earlier appointment were considered in the context of an earlier request for a *routine* appointment, not an *urgent* appointment. It is not clear from the information provided that his request was actually considered by the appropriate staff. I acknowledge that Mr A would have found the further postponing of his already overdue appointment extremely distressing, particularly in view of his request for urgency.

I note that Dr J did not mark his entry in the clinical notes for Mr A as "urgent" or "as soon as possible". Dr J noted in the medical records for this visit: "Review please in [Dr B's] clinic in 2–4 weeks."

This was an oversight by Dr J, and highlights the importance of medical staff completing their notes in accordance with the information provided to their patients, thereby reducing the possibility of misunderstandings. Ophthalmology Department staff did not know that delaying Mr A's routine appointment was potentially problematic as the request for the appointment by Dr J was not marked "urgent" so as to alert them.

Professor I advised me that if patients do wish to have an earlier appointment, this can be discussed with a nurse at the Clinic, but that generally patients are required to contact their general practitioner, who then contacts medical staff at the Eye Clinic to discuss the situation. However, there is no evidence to show that Mr A was advised or was aware that this was the appropriate course of action to take.

I note that the Eye Clinic sees approximately 45,000 patients per year, and is often overbooked, resulting in urgent cases taking priority. In June 2000, 1380 new patients and 2399 follow-up patients were seen at the Eye Clinic; in July 2000, 1222 new patients and 2157 follow-up patients were seen; in August 2000, 1265 new patients and 2323 follow-up patients were seen at the Eye Clinic. There are only 10.68 full-time equivalent ophthalmologists and six registrars in training employed in the Clinic to review all these patients. The Eye Clinic is currently examining how to highlight urgent cases and has acknowledged that this is a difficulty across ophthalmic referrals.

Mr A was also concerned that Dr B was unable to advise him why the appointment was postponed, in circumstances where it was clinically relevant. Dr B advised me that he is not able to comment on why there was a delay. I note Professor I's comments that many patients are rescheduled, and it does not appear unreasonable that Dr B would not have had immediate knowledge why a particular patient had not been rescheduled. I accept that this is not a matter about which Dr B would necessarily be able to provide an explanation, although it is apparent that it would have been helpful in circumstances where Mr A had experienced considerable delay and was understandably frustrated.

I acknowledge that ideally, while every patient with Mr A's condition should be treated as soon as possible after diagnosis, restraints on staff and resources make this an impossible goal. Furthermore, my advisor's opinion is that Mr A's clinical management was not impeded substantially by the delay that occurred between his examination by Dr J on 13 June and Dr B on 31 August 2000. However, my advisor also comments:

> "This however, does not mean that I support the concept that there is no degree of urgency for neoplastic cases. It would have been much more satisfactory for [Mr A] to have been seen as soon as possible after [Dr J's] diagnosis."

I am guided by the independent advice I received. In light of this advice, and taking into account all the surrounding circumstances, in my opinion the Ophthalmology Department of

the public hospital breached Right 4(5) of the Code in relation to this aspect of Mr A's complaint.

Accordingly, I recommend that the Ophthalmology Department ensures that, in scheduling Eye Clinic appointments, "urgent" cases are prioritised, patients' requests for earlier appointments are dealt with appropriately and patients are kept well informed.

Actions taken

- The issue of highlighting urgent cases was acknowledged by the Ophthalmology Department Eye Clinic of the public hospital as a difficulty across ophthalmic referrals; the issue is currently under review.

Further actions

I recommend that the Ophthalmology Department Eye Clinic of the public hospital take the following action:

- Once the review in relation to highlighting urgent ophthalmic referral cases has been completed, provide an update to the Commissioner setting out how urgent cases will be dealt with to prevent recurrence of the situation experienced by Mr A.

Other actions

- A copy of this opinion will be forwarded to the Medical Council of New Zealand.

- A copy of this opinion, with identifying features removed, will be sent to the Royal Australasian College of Surgeons, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.