A Public Hospital

Vitreo-Retinal Specialist, Dr C

A Report by the

Health and Disability Commissioner

Case 01HDC13673

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Dr A	Complainant
Mr B	Consumer
Dr C	Vitreo-retinal specialist / Provider
Dr D	Vitreo-retinal specialist
Ms E	Case Manager, ACC
Ms F	ACC staff
Ms G	ACC staff

Complaint

In November 2001 the Commissioner received a complaint from Dr A of the Accident Compensation Corporation (ACC) about health care services provided to Mr B by Dr C and a public hospital. The complaint was summarised as follows:

- *Dr C did not inform Mr B in a timely manner that he required further surgery on his left eye before mid-April 2001 and, in particular, Dr C did not:*
  - *inform Mr B of the requirement during the consultation on 22 March 2001;*
  - *inform Mr B about the need to contact ACC himself about the further surgery during the consultation on 22 March 2001;*
  - *follow up his advice in writing, owing to the delay in the typing of his letter, which was dictated on 22 March 2001 but not sent until 27 April 2001.*
- *Dr C did not advise ACC directly about the need for Mr B to receive further surgery on his left eye. (Mr B alleges Dr C owed him a duty of care to take reasonable steps to ensure he received the necessary surgery and that due to Dr C's negligence, Mr B did not receive the surgery needed to save the vision in his left eye.)*

An investigation was commenced on 1 May 2002.

Information reviewed

- The public hospital's notes in respect of Mr B
- Relevant records from ACC

Overview

In November 2001 I received a complaint from Dr A, General Manager, ACC Healthwise, concerning the services provided to Mr B by the public hospital and Dr C, a vitreo-retinal specialist working in the Eye Department at the hospital. Mr B sustained a penetrating eye injury in March 2001 for which he had surgery performed at the hospital. As Mr B's injury was caused by an accident, ACC covered the treatment provided. Mr B required a second operation, but there was a delay in informing ACC about the need for the further surgery. Mr B eventually lost the sight of his left eye. He confirmed that he supported the complaint by ACC.

Information gathered during investigation

On 14 March 2001, Mr B sustained a penetrating injury to his left eye after falling onto a steel stake at work. He was seen at the Accident and Emergency Department of the hospital and admitted for surgery to repair his ruptured left globe and left upper eyelid laceration. A consultant surgeon performed the surgery that afternoon. Mr B advised that the following day Dr C, the consultant surgeon, and Dr D, another vitreo-retinal specialist, discussed with him what had been done in surgery and explained that, as a result of his eye exploding, he had total retinal detachment. A further two to three operations were needed to repair his eye, and the first operation had to be within 30 days or the retina would become too hard and could not be re-attached. The next operation would involve draining out eye fluid, re-attaching the retina, and filling the eye with silicone oil. The doctors informed Mr B that he required ACC approval to proceed, but that this should not be a problem because ACC had recently met with hospital management and promised a five-day turnaround for authorisation. Mr B was discharged from hospital the next day, 15 March.

Dr D informed Mr B, before his discharge from hospital, that while there was a need for further surgery within approximately 30 days, it was not possible to perform the surgery within the next seven to ten days as his primary wounds needed to heal and the blood at the front of the eye needed to clear. Dr D told Mr B to inform his ACC case manager about this as soon as possible.

On 22 March, Dr C saw Mr B at the Eye Clinic in the Outpatients Department. Dr C recommended further surgery and dictated a letter, dated 22 March 2001, addressed to Mr B and "cc'd" (copied) to Dr C and Mr B. The letter stated that in Dr C's opinion, Mr B "would benefit from vitreo-retinal surgery on [his] left eye" and that:

> "unfortunately [the hospital] does not have an elective contract for ACC for ophthalmology. This will therefore necessitate [Mr B] contacting an ACC officer in [his] local area and seeking approval for a Vitreo-retinal Surgeon to carry out this work. The left eye has suffered significant injury and there is a real prospect that in spite of all intervention the vision in the left eye could be lost."

The letter was not typed until 27 April 2001 owing to a shortage of staff in the Ophthalmology Department at the hospital (a five-week delay).

Dr C advised me that he dictated the letter in Mr and Mrs B's presence and informed them that the hospital did not have an elective contract with ACC. He instructed Mr B to contact an ACC officer in his local area and seek approval for ACC-funded surgery. As Mr B did not have a general practitioner (having recently returned from overseas) and did not know where the nearest ACC office was, Dr C addressed the letter to Mr B.

Mr B advised me that he did not do anything about ACC because he did not know he had to and he thought the doctors at the hospital had sent the request for further surgery directly to ACC.

On 3 April Mr B telephoned his employer with an enquiry about his pay and was advised to visit an ACC office and complete some paperwork.

Mr B went to a branch of ACC where he met Ms E, who was appointed Mr B's case manager. Mr B informed Ms E that he required further surgery, that his specialist was Dr C and that he had follow-up appointments on 5 and 19 April. He also told her that he did not have a general practitioner. Mr B completed an Individual Rehabilitation Plan (ACC92), signed and dated 3 April 2001, which stated that "[Mr B] agrees to proceed with surgery as recommended by the specialist".

Mr B alleged that he informed Ms E that further surgery was required urgently and that it needed to be performed within 30 days of the accident. He asked Ms E what he could do to speed up the process. Ms E told him to obtain a copy of his medical records from the hospital. Mr B also informed Ms E that he thought Dr C's letter would have arrived by this time; Ms E told him not to worry as ACC had a pretty quick turnaround.

Mr B obtained a copy of his records from the hospital on 5 April, when he had a follow-up appointment with Dr C. As Mr B had not received Dr C's letter dated 22 March 2001, Dr C gave Mr B a hand-written note to take to ACC. The note stated that Mr B "needs referral to an ACC accredited Vitreo-retinal Surgeon". Mr B took the note and his records to ACC on 6 April.

During the consultation on 5 April Dr C examined Mr B and noted that "the eye was still inflamed and not ready for surgery". Dr C prescribed Voltaren, an anti-inflammatory, and arranged to see Mr B in two weeks' time. Dr C dictated a letter in Mr B's presence, stating: "In my opinion you require complex intraocular surgery to try and repair the damage done to your eye. I have advised you to see your ACC case officer who I understand is based at the … office." This letter was not typed until 14 June 2001 (a delay of five and a half weeks).

Dr C advised me that his goal was to reduce the intra-ocular inflammation before he undertook the surgery. He anticipated that Mr B would be seen by an ACC approved vitreo-retinal surgeon while Mr B's eye was still "salvageable".

Mr B telephoned Ms E at ACC on 11 April 2001. Ms E informed Mr B that a surgery request had not been received by ACC. She then telephoned Dr C, who advised that unless the need was acute, the surgery would not be performed at the hospital, and that he had not referred Mr B to another specialist. Dr C indicated that he would like to perform the follow-up surgery. Ms E telephoned Mr B and advised him to see a general practitioner to obtain a referral to a specialist "under the elective services system".

Mr B saw a general practitioner on 11 April 2001. The general practitioner completed a "Referral by General Practitioner" form (ACCM41) for Dr C. The referral was copied to Ms E and faxed to ACC that day. It is not clear when the referral was sent to Dr C. ACC's records state, under the heading dated 11 April 2001, 13:45: "Expected outcome has exceeded MDA duration because of the following reason: severity of injury. Further surgery required."

Mr B returned to the Eye Department at the hospital on 19 April for his follow-up appointment and was seen by Dr D. In Dr D's opinion, Mr B's surgical prospects were not very good. Mr B advised Dr D that there had been delays due to ACC waiting for his GP to provide a referral to Dr C at his private rooms. Dr D recorded the following in the notes: "Poor prognosis if significant further delay." Dr D completed a further ACC medical certificate (ACC18) dated 19 April 2001, which stated:

> "Left total retinal detachment requires urgent surgery approval. 2 letters already have been written indicating this. ACC delays are compromising this patient's care. We have previously been assured that ACC would guarantee a one-week turn around for approval for further surgery. I would be happy to support this patient in any legal action they might take against ACC for their delays."

On 20 April, Mr and Mrs B saw Ms E at ACC. ACC's records state:

> "Conversation with [Mr and Mrs B]. Very upset about what they perceive as ACC holding up eye surgery for [Mr B]. Very difficult to explain process as [Mrs B] in particular very upset. Tried to differentiate between role of ACC as funder and role of GP and specialist in directing treatment. IP [injured person] first seen by [Dr C] in public system when injury acute. Advised IP that needed to be referred to an ACC accredited specialist for further surgery. ([Dr C] is an ACC accredited specialist and has a contract with [a lead provider].) Problem arose because IP did not have a GP and did not understand that had to be referred by GP to specialist who would then complete an assessment report and treatment plan.
>
> Now has a GP in …. Have left a message asking him to ring me so can ensure he is aware of process. Also rang [Dr C's] rooms. Spoke to …. Advised her that once [Dr C] had seen IP on Tuesday at 8.20 am, if he decides elective surgery is needed, then needs to complete an ARTP and send to …. Advised that any difficulties re the process (which is in his contract) he can ring and discuss with [Ms E]. She will pass that on to both … (who does the ACC surgery bookings) and to [Dr C]."

Mr B saw Dr C in his private rooms on 24 April 2001. In Dr C's view, Mr B's eye was inoperable because of the scarring that had developed.

Subsequent events
On 30 April, Ms F at ACC sent a facsimile to Dr D requesting advice concerning Mr B's claim. The fax stated: "Was the need for the second proposed surgery acute or elective? (acute meaning that it was necessary for the surgery to be undertaken within seven days from the date of the decision to operate)." Ms F also asked Dr D why the operation was not scheduled to be undertaken in the public system if the need for the second surgery was considered to be acute. A similar fax was sent to Dr C. Dr C responded in his letter dated 2 May 2001 and he referred to his original letter dated 22 March 2001. It then became apparent to ACC that it had not received a copy of Dr C's letter dictated on 22 March 2001. Ms E contacted the hospital and found that the letter was typed on 27 April 2001. As Mr B had not received the letter he collected it himself from the hospital on 30 April 2001. Mr B had a meeting with the Branch Medical Advisor of ACC and Ms F on that date but, according to ACC's records, Mr B did not produce the letter. According to ACC, it received a copy of the letter on 10 May 2001.

Mr B saw Dr D again on 24 May 2001. Dr D completed another ACC medical certificate (ACC18), which stated that Mr B would most likely need a left enucleation and that he required referral to an ophthalmic plastic/orbital surgeon. Dr D suggested two doctors.

On 14 June 2001 one of the above doctors performed a left enucleation of Mr B's eye.

Need for second operation
Dr A, who made the initial complaint, stated that "communication failures between surgeons in [the hospital] and in Private and ACC resulted in a delay in accessing surgical treatment which led to this man losing the sight in his eye". Dr A also stated that "the failure to have the letter typed was only one form of communication available to the surgeon and the registrar involved. The surgeon in particular, appeared to clearly understand that urgent intervention was required and yet his correspondence with ACC in arranging elective surgery gave no hint of that urgency." Dr A also referred to the interface between the public and private provision of ophthalmology services in the region.

Mr B informed me that he supported the complaint and questioned why a specialist with a long history of dealing with ACC was unable to implement ACC procedures. According to Mr B, staff at ACC had said to him that Dr C could have changed his eye from elective to acute at any time, and he questioned why Dr C did not "make it acute".

Having carefully considered the matter, it appears to me that a fundamental issue in this complaint is the alleged non-notification to ACC that Mr B required acute surgery. However, there is an issue with the word "acute".

Ms E, Mr B's case manager at ACC, understood that when Mr B first saw Dr C (22 March 2001), his need for the second operation was acute. ACC notes record: "first seen in by [Dr C] in public system when injury *acute*" (emphasis added).

According to other documentation from ACC (Ms F's letter to Dr D dated 8 May 2001), "acute" meant that it was necessary for the surgery to be undertaken within seven days from the date of the decision to operate. ACC advised (the Chief Advisor, Customer Relations, in his letter dated 30 January 2003) that an acute admission was a consideration or option when Dr C subsequently examined Mr B during either or both of the consultations held on 5 and 19 April 2001. He acknowledged that the acute option might not have been applicable at the time of the consultation on 22 March 2001. The Chief Advisor did not define "acute" in his letter, but Dr A, in his letter dated 29 May 2002, stated that "if surgery was considered urgent ie required within seven days of the surgeon's decision to admit the patient" then the surgery must take place within the public sector. Dr A also stated that if surgery was considered urgent but able to be undertaken outside the seven-day period, then ACC would expect Mr B to be referred either to his GP for referral to an appropriate specialist, or directly to an alternative specialist.

I am satisfied that when Dr C saw Mr B on 22 March he did not consider that Mr B required acute surgery – within seven days. Nor did Dr C consider that surgery was needed in seven days when he saw Mr B on 5 April. Dr C stated that, in his clinical judgement, Mr B's left eye was still significantly inflamed on 5 April 2001, and his goal at the time was to reduce the intra-ocular inflammation sufficiently before he undertook surgery. I have received no information that leads me to the view that Dr C's clinical decision was inappropriate. Dr C prescribed anti-inflammatory medication and booked a further appointment to see Mr B in two weeks' time.

The consultation on 19 April 2001 was with Dr D, who recorded a "poor prognosis if significant further delays". Dr D was aware from Mr B that he was due to see Dr C in five days' time on 24 April 2001. I note Dr D's comments that Mr B may not have had a different outcome irrespective of surgical timing. This confirms Dr C's initial advice that there is "a real prospect that in spite of all intervention the vision in the left eye could be lost".

Like Dr C, Dr D also did not consider the matter acute. He advised that in respect of ACC's guidelines, the need for the second operation was elective and not acute and that Mr B had a finite window of about four to six weeks in which to proceed with the next stage.

Communication with ACC

Mr B sustained a personal injury by accident on 14 March 2001 and was therefore eligible for medical services to be funded by ACC. For ACC to make the appropriate payments it was necessary for it to be informed about Mr B's changing health needs. ACC, as a funder of health care services, has in place processes with which it expects providers of health care services to comply. However, Mr B's case did not fit the usual categories. Dr A advised that if surgery was considered urgent but able to be undertaken outside the seven-day period (which I am satisfied was the situation), ACC would expect Mr B to be referred either to his general practitioner for a referral to an appropriate specialist, or directly to an alternative specialist.

Mr B did not have a general practitioner, a matter noted and acted upon by Dr C at Mr B's first post-operative consultation on 22 March 2001. In Dr C's view, when a patient does not

have a general practitioner, the patient should "be told to present to the nearest ACC branch for assistance" and the "appropriate management instituted. Each ACC Branch has a visiting doctor who is able to evaluate the clinical information and assist in this process." Dr D also said that "even though a public clinician might feasibly arrange transfer of patients' care into the private sector, ACC must first authorise funding for the process". The hospital advised that "ACC must refer patients to a contracted provider for services after the initial 7 days post injury" and that "if further treatment is necessary after the initial acute period ACC should facilitate referral to a contracted provider". Dr C advised that Ms G of ACC had informed him that where patients require referral to a private specialist, the referral should take place within two weeks from the time the clinical information is supplied to ACC.

Following the consultation on 22 March, Dr C was seeking funding approval for the further surgery required by Mr B, so that when his eye was operable the surgery could proceed in the private sector without delay. Dr C is an ACC accredited provider who provides ophthalmology services at the Eye Clinic. As such, he could have referred Mr B to himself for the second operation. According to ACC it was up to Dr C to do this.

ACC advised me that it expects surgeons operating in the public sector to refer patients to themselves for further treatment and surgery should it need to be performed in the private sector. It further stated that direct referral to an alternative specialist is an option, and that the choice of specialist and the need for surgery in the public or private sector would be made as a result of discussions between the patient and the referring medical practitioner, in light of the clinical need. ACC stated that it is not its role to receive and co-ordinate treatment referral processes between medical practitioners, and that no specific guidelines have been developed or issued by ACC in respect of surgery.

There appears to be a significant and fundamental misunderstanding of the procedure that is to be followed where there is not an elective contract with ACC for services. The hospital, Dr D and Dr C share the view that ACC has a role to play in this process. ACC clearly disagrees.

The communication issues, highlighted by this complaint, including the misunderstanding about Mr B's need for elective, as opposed to acute surgery, are not matters that fall within my jurisdiction. The Code of Health and Disability Services Consumers' Rights (the Code) does not include a right of access to health care services, and the Commissioner has no jurisdiction to consider whether sufficient funding is available to ensure delivery of timely services. Accordingly, no further action will be taken in respect of this aspect of the complaint.

Response to Provisional Opinion

The hospital
The hospital submitted, in response to my provisional opinion, that ACC does fall within the Commissioner's jurisdiction as ACC processes impact directly upon patient care. The hospital referred to section 69(1)(a) of the Injury Prevention, Rehabilitation, and Compensation Act 2001, which states that the entitlements under that Act are rehabilitation, comprising treatment, social rehabilitation and vocational rehabilitation. In the Board's view there is nothing in the ACC legislation that exempts ACC from falling within the Commissioner's jurisdiction under the Health and Disability Commissioner Act 1994 (the Act).

The Commissioner's functions are set out in the Act and include the investigation of alleged breaches of the Code. A breach of the Code in respect of health services can occur only when there is a health care provider and a consumer. "Health care provider" is defined in section 3 of the Act. ACC does not fall within sections 3(a)-(j) and, therefore, for ACC to be considered a provider, it must meet the criteria set out in section 3(k), which defines a "health care provider" as any person who provides, or holds himself or herself or itself out as providing, health services to the public or to any section of the public, whether or not any charge is made for those services.

ACC does not provide health services. The purpose of the Injury Prevention, Rehabilitation, and Compensation Act "is to enhance the public good and reinforce the social contract represented by the first accident compensation scheme[1] by providing for a fair and sustainable scheme for managing personal injury that has, as its overriding goals, minimising both the overall incidence of injury in the community, and the impact of injury on the community (including economic, social, and personal costs)".

To fulfil its statutory functions ACC has implemented processes that must be followed when a health care provider provides health services funded by ACC. Imposing requirements on agencies that provide health services – to ensure that public money is spent in accordance with the scheme of its legislation – does not make ACC a health care provider for the purposes of section 3(k) of the Health and Disability Commissioner Act, even if those processes do impact on the provision of health services. In any event, the Injury Prevention, Rehabilitation, and Compensation Act defines, in section 6, a treatment provider as an acupuncturist, audiologist, chiropractor, counsellor, dentist, medical laboratory technologist, nurse, occupational therapist, optometrist, osteopath, physiotherapist,

[1] Section 26(1) of Accident Compensation Act 1982 stated that "The purposes of this Act shall be –

(a) To promote safety, including occupational health:
(b) To promote the rehabilitation of persons who suffer personal injury by accident:
(c) To make provision for the compensation of persons who suffer personal injury by accident and certain dependants of those persons where death results from the injury."

podiatrist, registered medical practitioner or speech therapist; and includes a member of any occupational group included in the definition of "treatment provider" by regulations made under section 322.

In summary, in my opinion there is no jurisdiction for the Commissioner to consider whether the actions of ACC in relation to Mr B were in breach of the Code as ACC is not a health care provider.

ACC
In response to my provisional opinion, ACC advised that the clinician who identifies the need for treatment of a person has a responsibility to ensure that treatment is carried out, and that Dr C inappropriately abrogated his responsibility in the case of Mr B. ACC referred to the ACC process, which encourages the treating clinician to complete an ARTP (Assessment Report and Treatment Plan) seeking prior approval for surgery at any time. ACC expected Dr C to have completed an ARTP in respect of Mr B as soon as he became aware that additional surgery might be required, and stated that the ARTP should have recorded that the time of surgery could not be explicitly determined.

During the course of my investigation, ACC forwarded me a copy of the generic elective services agreement. Schedule 3 of the Service Specification for Clinical Services sets out (at point 6) the requirements of an ARTP. However, the schedule also notes that "a letter to the Claimant's General Practitioner from the Specialist will be regarded as an ARTP if it includes all the information set out in this clause 6.4. It is ACC's preference to receive a copy of such a letter to the Claimant's GP."

I note that Dr C did write such a letter and, since Mr B did not have a GP, instructed Mr B to take the letter to ACC.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' 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.*

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; and

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 – Dr C

Mr B confirmed that he supported the complaint that Dr C did not inform him in a timely manner that he required further surgery on his left eye before mid-April 2001.

According to Mr B, he was informed following his surgery, and before his discharge from hospital, that he required further surgery. However, when that surgery was needed was unclear. At Mr B's second consultation, Dr C considered that Mr B's eye was still inflamed, and therefore not ready for surgery. Dr C's goal was to reduce the intra-ocular inflammation before he undertook the surgery. The timing of surgery was to be determined by improvement in Mr B's eye, which could not be precisely indicated. I note Dr D's comments that there was a finite window of about four to six weeks in which to proceed to the next stage of surgery. Even though a precise time could not be provided to Mr B, he appears to have been aware that surgery was needed. He told Ms E that surgery needed to be performed within 30 days of his accident. There is therefore no substance to the allegation that Mr B was not informed about the requirement for further surgery.

Mr B has also complained that Dr C did not inform him about the need to contact ACC himself about the further surgery. Mr B did not take any steps to contact ACC following his consultation with Dr C on 22 March, and appears to have contacted ACC only after speaking to his employer to enquire about his pay on 3 April. At that stage he was advised to visit an ACC office.

In contrast, Dr C said that he informed Mr and Mrs B that the hospital did not have an elective contract with ACC and that Mr B would need to contact an ACC officer in his local area to seek approval for the ACC-funded surgery. In the presence of Mr and Mrs B Dr C dictated the letter dated 22 March 2001, which stated the need for Mr B to contact an ACC officer in his local area (although there was a delay in Mr B receiving this letter).

Dr D also said that when he saw Mr B on 15 March 2001, following his surgery and before his discharge from hospital, he told Mr B to present himself to his ACC Case Manager to inform her that further surgery within seven to ten days of the initial surgery was not feasible because the primary wounds needed to heal. However, further surgery was needed within about 30 days.

Although there was clearly some misunderstanding about the process involved in seeking funding approval from ACC, I can find no substance to the allegation that Mr B was not informed about the need to contact ACC himself.

Mr B also complained that Dr C failed to inform ACC directly about the need for further surgery on his left eye.

According to ACC, the procedure that should have been followed by Dr C was to make a referral directly to Mr B's general practitioner, if he had one, or alternatively, to make a referral to a specialist under the elective services system. Following ACC's procedures, there was no need for Dr C to contact ACC directly. Accordingly, there can be no breach of the Code in this respect.

During the consultation on 5 April it became apparent to Dr C that Mr B had not received the letter dated 22 March (as it had not been typed). Dr C provided Mr B with a handwritten note to take to ACC. However, he did not follow up within the Ophthalmology Department the letter he dictated on 22 March. It was not on the file and Mr B had informed him that it had not been received. It was therefore up to Dr C to make enquiries within the typing department about the location of the letter.

At that time, it was two weeks (ten working days) since the letter had been dictated. In my view, Dr C could reasonably have assumed that the letter was in the post and that Mr B would soon receive it. In the absence of evidence to satisfy me that the hospital took steps to inform surgeons about the delay in typing, I am persuaded that Dr C had no reason to believe that the letter had not been typed. Accordingly, in my opinion Dr C did not breach the Code in relation to this matter.

Opinion: Breach – The Public Hospital

Irrespective of the requirements and the subsequent discussion between ACC and the hospital concerning the referral process, there was an unacceptable delay in the typing of Dr C's correspondence. In my opinion, the delay in the typing of two letters dictated by Dr C is a breach of Right 4 of the Code by the hospital.

On 22 March 2001, Dr C dictated a letter addressed to Mr B in the absence of him having a general practitioner, and in light of Dr C's apparent reluctance to self-refer. The letter was not typed until 27 April 2001 and, according to the records, not provided to Mr B until he collected it in person on 30 April 2001. A second letter dictated by Dr C addressed to Mr B was dictated on 5 April 2001 and not typed until 24 June 2001.

In my view, the delay in the typing of the first letter contributed to the confusion and misunderstanding about Mr B's condition and need for surgery. A four-week delay in the typing of correspondence in an acute surgical setting is not acceptable, even in a resource-constrained public hospital.

During the course of my investigation I put a number of questions to the hospital about this matter. I was informed that the delay in the typing was due to personnel shortages and that there was a delay in typing of non-urgent letters of up to four weeks. Both Dr C's letters to

Mr B were delayed for over four weeks. The hospital informed me that all staff within the service, including surgeons, were aware of the problems associated with typing, and that surgeons were informed of the procedure for urgent typing within the department. The hospital advised that it now has sufficient typists within the department for letters to be turned around in one to three days. The hospital did not, however, provide me with copies of memos or emails to staff informing them about the typing delay in 2001 or provide details of when the problem was rectified.

This concerns me, particularly given that the second letter, which was dictated on 5 April 2001, was not typed until 14 June 2001. Dr C advised me that he could not recall being made aware that there was a delay in typing services during March and April 2001. Both he and Dr D understood that Dr C's letter dictated on 22 March 2001 had been typed and sent. Dr C wrote to ACC asking why it had not responded to his letter dated 22 March.

In the absence of further detail, and on the evidence presented to me, I am satisfied that the hospital did not take reasonable steps to ensure that urgent letters were typed and sent, and therefore breached Right 4(1) of the Code.

Other comment

Communication
I am concerned by the significant failures of communication evident in this case. The misunderstanding of staff at the hospital about the role of ACC, and the seemingly inflexible attitude of ACC about what steps should be taken by doctors where there is no ACC contract and the patient does not have a general practitioner, means that this scenario could occur again. I am not satisfied that the processes now in place will ensure that the next patient who has no general practitioner and requires further non-acute surgery will not be the victim of the circumstances encountered by Mr B. There is no doubt that the delay in typing was an issue, but not the only issue. The primary matter that led to a failure to provide adequate services was the lack of understanding about the required referral process when Mr B with no general practitioner. Dr C was reluctant to refer Mr B to himself for treatment.

I note that the ethical responsibilities of doctors make the practice of self-referral problematic, particularly where the referral is to the private sector where the practitioner will benefit financially. I accept that in such cases a practitioner may be reluctant to self-refer. The Chief Advisor from ACC suggested that ACC's expectation is that surgeons operating in the public sector would refer patients to themselves for further surgery in the private sector. This matter has been the subject of discussion between ACC and the hospital.

According to the hospital, a meeting with ACC representatives was held on 18 June 2001 and it was agreed that ACC would provide a set of clear guidelines for future management of this type of situation within six weeks of the meeting. The hospital also referred to an

assurance by Ms G that authority for funding by ACC should not take longer than one week.

ACC advised me that there were two meetings involving ACC, and Dr C and a surgeon in the hospital's Eye Department.

At the first meeting on 5 April 2001 Ms G informed Dr C and the surgeon that it was the specialist's responsibility to facilitate the referral process and to ensure that a system was in place to manage this effectively. It was suggested that a referral could be arranged via the patient's general practitioner, given a doctor's discomfort about self-referring from the public to the private sector. This does not, however, address the issue, central to this complaint, of patients who do not have a general practitioner. ACC also recognised that a timely turnaround was necessary and advised that Ms G would work with the ACC Rehabilitation Contracts Advisor to ensure that ACC branch offices within the region made a decision on funding within two weeks of the specialist submitting an ARTP. ACC advised me that it was made clear to Dr C and the surgeon that it was their responsibility to design and implement a referral process, although ACC agreed to provide some input. A template referral form was drafted, but could not be progressed as ACC decided that it would be inappropriate to have an active role in the design of a referral form. ACC stated that staff failed to notify Dr C and the surgeon that ACC could not assist with the template.

Other options
Instead of self-referring Mr B for his second operation, Dr C could have referred him to the other vitreo-retinal surgeon who had a contract with ACC to perform elective surgery in the private sector. He did not do so, presumably because he wished to perform the surgery himself albeit with ACC facilitating the referral. This fastidious approach by Dr C was unhelpful to his patient in the circumstances of this case.

Actions taken

The hospital has apologised to Mr B for its breach of the Code. It has taken the following steps in response to this case:

- In January 2003 the hospital employed a full-time ACC co-ordinator to ensure that ACC patients are appropriately identified and have procedures carried out in a timely manner. ACC approval for core procedures is usually received by the hospital within 48 hours; approval for non-core procedures can take up to 20 working days

- Three full-time typists are now employed in the Ophthalmology Department at the hospital. (At the time of these events, there were one and a half full-time typists, assisted by a succession of temporary typists.)

- Urgent letters are now usually typed within hours.

Further actions

- A copy of this report will be sent to the Minister of ACC and the Minister of Health to draw their attention to the problems identified in this case in relation to the referral process for ACC-funded non-acute eye surgery in the respective city.

- A copy of this report, with personal identifying details deleted, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.