Ophthalmologist, Dr B

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 05HDC16595)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Mrs A	Consumer's wife
Dr B	Provider/Ophthalmologist
A District Health Board	Provider/Eye Clinic Services
Ms C	Registered nurse
Dr D	Vitreoretinal surgeon, a city hospital

Complaint

On 18 November 2005, the Commissioner received a complaint from Mr A via a Health and Disability Consumer Advocacy Service about ophthalmic services provided by Dr B. The following issues were identified for investigation:

- *The adequacy and appropriateness of the surgical procedure provided by Dr B on 1 November 2004.*

- *The adequacy and appropriateness of the surgical procedure provided by Dr B on 9 November 2004.*

- *The adequacy and appropriateness of the care and treatment provided by Dr B from 1 November to March 2005.*

An investigation was commenced on 2 March 2006.

Information reviewed

- Information from:
  - Mr A
  - Dr B
  - Ms C
  - A District Health Board
  - Dr D
  - Medical Council of New Zealand
- Mr A's medical records from the Eye Clinic, a District Health Board
- Mr A's medical records from the Emergency Department, a District Health Board
- ACC records in regards to this injury

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Independent expert advice was obtained from Dr Phillip Polkinghorne, Associate Professor of Clinical Ophthalmology.

Overview

Mr A had cataract surgery undertaken by Dr B on 1 November 2004. The surgery resulted in a vitreous haemorrhage, and Dr B operated again on 9 November to remove Mr A's intraocular lens.

The haemorrhage was slow to clear and the visual acuity in Mr A's eye remained low over a three-month period. Mr A's retina had detached and Dr B referred Mr A to specialist vitreoretinal surgeon Dr D on 11 March 2005.

Dr D operated on Mr A's eye on 21 June 2005. He attempted to reattach the retina and noted some unusual tears, which he felt may have been caused by Dr B's surgery. Unfortunately, Mr A's retina detached again and it was decided that the probability of success with any further surgery was limited.

Mr A was concerned whether the surgery techniques used by Dr B were performed adequately and whether the referral to Dr D should have occurred earlier. Mr A reviewed his clinical record and found some errors in the record- keeping.

Information gathered during investigation

Initial referral
In February 2004, an optometrist referred Mr A, aged 82 years, to Dr B for possible cataract surgery. At that time Dr B did not feel surgery would improve Mr A's vision and they agreed to review the situation later in the year.

At the next review on 8 October 2004, Mr A's left eye showed some changes and Dr B felt that cataract surgery was now appropriate.

Surgery on 1 November 2004
The surgery was performed on 1 November 2004. Dr B administered a local anaesthetic to Mr A's eye. Dr B completed the surgery without any apparent problems, although he noted that the procedure was difficult owing to Mr A's deep-set eyes, which made the operation site small and deep.

Postoperative follow-up
The day after the surgery, on 2 November, registered nurse Ms C examined Mr A, as Dr B was busy in the operating theatre. She reviewed Mr A's eye and examined the

conjunctiva, cornea, pupil, and anterior chamber and pupil. She also took intraocular pressure, which she measured at 18mmHg.[1] She advised Mr A to return to the clinic the next day to see Dr B.

Mr A recalls the examination on 2 November differently from the record in the clinical notes, which he states is in error. Ms C initially saw him and removed his eye patch, but Mr A recalls that because he could not see, she asked Dr B to attend. Mr A says that he informed Dr B that he had no vision in his left eye and could only see a dark colour. Mrs A, who was present at the time, supports her husband's recollection.

In his letter to a colleague on 11 November, Dr B states that the date of his first examination of Mr A was 2 November.

Ms C confirms that she saw Mr A, without Dr B present, on 2 November. She also confirms that she was with Dr B when he saw Mr A on 3 November. This agrees with the record in the clinical documentation. On balance, I consider it probable that Dr B saw Mr A on 3 November, as recorded in the medical notes, and that his letter to his colleague contained an error regarding the timing of this consultation.

According to the clinical record, at his review of Mr A on 3 November Dr B noted that Mr A had "counting finger" vision in the left eye. Mr A says he had no vision in the eye.

The intraocular pressure was measured as 9mmHg. Dr B explained:

> "The change in intraocular pressure did not alarm me as this is often the case on the second day when the fluid that was placed inside the eye to reform the anterior chamber, has had time to settle down. So no alarms were triggered."

Dr B cautioned Mr A that a strong sneeze could affect the healing process. Mrs A remarked that when Mr A sneezed, he usually had a "hearty sneeze".

Emergency Department record

On 2 November, an unidentified staff member made an entry in Mr A's medical records about a contact made by Mr A with the Emergency Department at a provincial hospital on the night of 1 November, because of nausea and pain. The entry is unsigned and the writer has not been identified.

Mr A states that he did not attend or call the Emergency Department on 1 November. Clinical notes from the department confirm that Mr A did not make any contact in early November, but attended on 10 and 18 November for reasons unrelated to his eye surgery.

[1] Measurement of pressure in the eye. 10 to 21mmHg is the normal range.

Second operation
Five days later, on 8 November 2004, Mr A called the clinic because he had pain in his left eye and a "red blob" in his vision. Clinic staff arranged an appointment straightaway. Ms C measured the intraocular pressure as 7mmHg. Dr B also examined Mr A. He documented that Mr A's symptoms began after sneezing violently. The intraocular lens had displaced and a haemorrhage had occurred. Dr B's recommendation was to return to the operating theatre the following day to remove the lens.

Mr A strongly disputes that he sneezed, and denies that this was reported to Dr B. On this issue, Dr B is "quite happy to accept his [Mr A's] word on it" and is aware there are other possible causes for the haemorrhage apart from a sneeze (letter dated 5 December 2005). He apologised to Mr A for misunderstanding that the report of sneezing was a general observation and not an event of sneezing. Dr B did not intend to imply that Mr A was in any way responsible for the subsequent events. I note, however, that Dr B also said in his letter of 14 March 2006, "Is it any wonder one noted sneezing as this could have produced just that [referring to the haemorrhage]."

Dr B operated for the second time on 9 November to remove the lens. This time the surgery was completed under a general anaesthetic. Dr B has confirmed that the lens was removed "without undue difficulty".

The day after the surgery, on 10 November, Ms C reviewed Mr A and measured the intraocular pressure in his left eye as 8mmHg.

Second postoperative follow-up
On 15 November 2004, Mr A telephoned the clinic with concerns about side effects from the steroids prescribed to suppress intraocular inflammation. An appointment was arranged to review him at the eye clinic the following day. At the review, Dr B noted that there was some blood in the vitreous cavity, which was beginning to be absorbed. At that time he could not see the retina and gave Mr A a subconjunctival injection to help reduce inflammation.

Mr A saw Dr B again on 22 November and 13 December. The intraocular pressures remained low, at 6mmHg and 5mmHg respectively. On 13 December Dr B raised concern about the possibility of retinal detachment. He documented that Mr A had noted a minor change in his eyesight, which Dr B described as "a noted entopic phenomenon".[2]

On 21 December, Mr A attended the Emergency Department because of changes in his vision. The Emergency Department staff contacted staff at the Eye Clinic and

[2] A change observed that has occurred in the appropriate place. In Mr A's case, he had noticed a change in the status of his eye, and Dr B examined the kind of change and deduced that the change was beneficial.

were advised to take blood tests for infection screening. The results of the blood tests did not indicate that any treatment was required.

Mr A next consulted Dr B on 10 January 2005. The intraocular pressure rose to 10mmHg. Dr B said that he thought he could see the optic nerve for the first time and advised Mr A to wait and see if further blood was absorbed naturally. Dr B would then decide whether to refer Mr A to a vitreoretinal surgeon.

The next review took place on 7 February. Dr B decided that Mr A's eye was still clearing and advised him to wait a further three months.

However, Mr A returned one month later on 9 March. Dr B was still unable to see the retina and documented his concern at the "very real possibility of a tractional retinal detachment". He wrote a letter referring Mr A to Dr D, a vitreoretinal surgeon at a city hospital, on 11 March.

At a consultation on 16 May, Dr D diagnosed a total retinal detachment below the haemorrhage. On 21 June, Dr D performed surgery to re-attach the retina. According to Dr D, there were three unusual tears in the retina. In his discharge summary he suggested there may have been a needle injury when the local anaesthetic was given by Dr B.

Dr B does not accept Dr D's suggestion. Dr B explained that only the first operation was completed with a local anaesthetic using a needle and syringe to deliver the anaesthetic directly into the eye. The second operation was completed using a general anaesthetic. Injections to the eye were performed only on 1 November, and therefore any needle injuries could only have occurred during that surgery.

Dr B stated:

> "I personally gave the peribulbar local anaesthetic and I am completely sure in my own mind that there was no possibility of this happening … Having said that, it is not an impossibility, even with all possible care being taken."

Dr B further suggested that the tears could have occurred during the process of removing the intraocular lens on 9 November 2004.

Mr A understands that if Dr B had acted more quickly and the operation by Dr D had been completed sooner, the sight in his left eye may have been better than the significantly reduced vision he now has.

Dr B's responses

Following Mr A's complaint to the District Health Board, Dr B accepted Mr A's explanation about sneezing and apologised for any inference that he was responsible for the haemorrhage.

Dr B is studying this aspect of ophthalmology as part of update training required by the Medical Council. He has purchased new equipment and a new textbook.

Dr B maintains that the probable cause of Mr A's complications is age-related degenerative disease. Dr B believes that waiting for the blood in Mr A's eye to disperse was an appropriate course of action. There would have been difficulties in undertaking further surgery to remove the blood due to the Christmas holiday period. Dr B has decided to consider the use of ultrasound in similar situations in future.

Independent advice to Commissioner

The following expert advice was obtained from Dr Phillip Polkinghorne, Associate Professor of Clinical Ophthalmology. In summary, Dr Polkinghorne advises that Mr A's surgery on 1 November and 9 November 2004 was appropriate and of an adequate standard. He also advises that the postoperative care between those two operations was also satisfactory. However, after the 9 November surgery, Dr B should have been alert to the fact that there was a high chance of Mr A having a retinal detachment, as his intraocular pressure remained low and his eye had very poor acuity throughout November and December 2004. Dr B should have referred Mr A for an ultrasound before 11 March 2005.

> "My opinion is based on the information provided by your office, which includes the supporting information from [Mr A], [Mr A's] medical records from [a DHB], the information provided by [Dr B and Dr D].
>
> My vocation branch of medicine is Ophthalmology and I have sub-specialty expertise in vitreoretinal surgery. I am a Clinical Associate Professor at the University of Auckland and perform clinical research into matters relating to vitreoretinal problems in New Zealand. I have special expertise in retinal detachments following cataract surgery and in March 2006 published a paper in a peer reviewed journal detailing the risks of retinal detachment following cataract surgery. I have also written on the risks of a regional anaesthesia associated with peribulbar anaesthesia and described the clinical signs associated with this complication.
>
> I have practised Ophthalmology in New Zealand for sixteen years. I regularly perform cataract surgery on complicated high-risk eyes.
>
> I have endeavoured in this report to answer the specific questions raised by your Office and have endeavoured to answer specifically some of the concerns raised by [Mr A].

I have reviewed the pre-operative assessment and the consent form. I believe the request and agreement to treat protocols developed by [the provincial hospital] and followed by [Dr B] are of a high standard.

[Dr B] identified prior to the surgery that [Mr A's] eyes were deeply set and that surgery may be difficult.

Surgery was scheduled for 1 November 2004 and the anaesthetist's notes record the local anaesthetic was performed by [Dr B]. The hospital notes state that a peribulbar anaesthetic was given and that the cataract was removed using phacoemulsification techniques.

The surgeon comments that the surgery was difficult because of the visibility and that the anterior chamber was deep. The surgeon comments that the lens had to be flipped in order to see the posterior section and I assume this refers to the crystalline lens and reflects the difficulty in removing the cataractous lens. I note however that no sutures were used during the surgery and there are no references to the surgery being complicated.

The anaesthetic record gives an indication of the duration of the surgery and the surgery does not appear to be unduly prolonged suggesting in fact that the surgery, although difficult, was uneventful.

There is no contemporaneous discharge letter following the cataract surgery. I will comment on this later in my report.

[Mr A] maintains in his version of events that [Dr B] saw [Mr A] on the first postoperative day, namely 2 November 2004. [Dr B] denies this. In [Dr B's] letter dated 14 March 2006 to [the Deputy Commissioner], and again in a letter dated 10 November 2004, [Dr B] states that the first day post operatively the eye appeared satisfactory, although the fundal view was a little hazy.

In my opinion this indicates that in fact [Dr B] did see [Mr A] on the first postoperative day, as I believe this comment could only have been provided by an ophthalmologist and there was no evidence to suggest that [Mr A] was reviewed by another ophthalmologist on that first post operative day.

I do not believe a senior clinic nurse, unless extremely experienced in ophthalmology, would be able to discern this clinical sign.

In [Mr A's] evidence he maintains that he was unable to see with the left eye following surgery. However, the notes on the 3.11.04 record the visual acuity and the record supports that there was count fingers vision in [Mr A's] left eye at one metre.

The writing, although I am not an expert on hand-writing, is different from [Dr B's] and I think the evidence suggests that [Mr A] did have vision in his left eye

on the 3.11.04. [Dr B] notes that the wound was secure, that the pupil was round and reacting and the intraocular lens was central. He comments that the fundus could be viewed although the view was hazy. He arranged to see [Mr A] again in two weeks time. However, [Mr A] reported back on the 8.11.04 with a painful left eye and reported a 'red blob' in his vision. At that stage his vision was worse having deteriorated to perception of light. The pressure in his left eye was reduced to 7 mm/Hg. At this time [Dr B] noted that the intraocular lens was subluxed and there was a vitreous haemorrhage.

Surgery to remove the intraocular lens was performed on the 9.11.04 under general anaesthesia. The intraocular lens was removed and [Dr B] notes on the operation record that no vitreous was encountered. The surgical wound was closed with sutures at this stage.

It was noted pre-operatively and recorded on the discharge diagnosis that vitreous haemorrhage was present. On the first post operative day following the second surgery the patient was again seen at [the provincial hospital], although it is not clear from the notes when the next post operative visit was to be scheduled. However it was recorded in the notes that on the 15.11.04 that the patient was unwell and arrangements were made to see him on the 16.11.04.

[Mr A] was seen by [Dr B] on that day (16.11.04) and [Dr B] noted that the vitreous haemorrhage had decreased sufficiently for an orange reflex to be vaguely recognised. The patient had hand movement vision only.

A week later the vision was worse at perception of light, the pressure was low, and [Dr B] notes that the posterior capsule was thickened with a central opening and that the capsule was disrupted. [Dr B] comments that no visualisation was possible at that stage presumably referring to the retina because of the vitreous haemorrhage.

[Mr A] was again seen on the 13.12.04 and again his intraocular pressure remained low and his vision poor in the eye at perception of light. [Dr B] raised the possibility of a retinal detachment at that stage.

The notes record the next visit on the 10.1.05 and [Dr B] recorded the vision was still poor in the left eye at perception of light. However, [Dr B] noted that for the first time he was able to see the optic nerve and two blood vessels. One month later on the 7.2.05 [Dr B] noted there was still clearing suggesting that the vitreous haemorrhage was clearing from [Mr A's] left eye. No comment on the retina is made.

On the 9.3.05 [Dr B] noted the vitreous has become more opaque and the blood has changed to a yellow colour and no retinal detail is visible. [Dr B] comments that [Mr A] should be referred for a vitreoretinal opinion.

On the 11.3.05 a letter is written to [a vitreoretinal surgeon at the city hospital]. In this letter [Dr B] recalls the history and comments that on the 3.11.04 he performed routine phaco lens removal and IOL implant. He subsequently comments 'the following day the eye showed a secure wound, clear media, and a round, reacting pupil and central IOL. The fundus was seen well but the vitreous looked hazy.' Again, this suggests that [Dr B] did see [Mr A] on the first postoperative day. [Dr B] notes also in this letter that on 7.2.05 that [Mr A's] vision had improved from light perception only to hand motions. This is not supported in the contemporaneous hospital records where it clearly states vision in the left eye on the 7.2.05 was still perception of light.

The subsequent information from the Department of Ophthalmology [at the city hospital] by vitreoretinal surgeon, [Dr D], recalls that there was a vitreous haemorrhage in Mr A's left eye and ultrasound showed a total retinal detachment. Surgery was performed one month later on the 21.6.05.

[Dr D] was successfully able to re-attach [Mr A's] retina. [Dr D] noted at the time of the surgery there was a row of what he described as 'three unusual linear tears along the inferotemporal periphery extending towards the macula.' He formed the opinion that this was secondary to a needle injury at the time of his local anaesthetic and raised the possibility that this may have occurred at the time of his second operation. I will return to this later in my report.

Following re-attachment of [Mr A's] retina, he returned to [Dr B] and subsequently [Dr D] re-operated on Mr A to remove the silicone oil from his left eye in an elective procedure. Regrettably the retina re-detached following this latter procedure and [Dr D] notes in his records that the option of further surgery was discussed with [Mr A]. At that stage it was thought that further surgery would not [be] likely to be successful and indeed further surgery was not undertaken.

The Commissioner has asked for me to comment on ten questions, which I will now answer:

Were the services provided by [Dr B] to [Mr A] following the surgery of 1 November 2004 of an appropriate standard?

I have reviewed the notes made by [Dr B] on [Mr A] pre-operative, intra-operative, and immediate post-operative notes, together with comments from the nursing staff at [the provincial hospital].

I am of the opinion that the services provided by [Dr B] during this period were adequate and indeed comprehensive.

In my opinion the only two points which I think were questionable was the failure to record the visual acuity on the first postoperative day, together with the absence of a suitable discharge letter to the family doctor at this stage.

I have formed the opinion that [Mr A] was indeed seen by [Dr B] on the first postoperative day, namely the 2.11.04, as [Dr B] comments in two subsequent letters that the ocular fundus was visualised. I believe this could only have been performed by an Ophthalmologist in this clinical setting.

Were the services provided by [Dr B] to [Mr A] during the surgery of 1 November 2004 of an appropriate and adequate standard?

I believe they were and that [Dr B's] management on the 3.11.04 was satisfactory in that [Dr B] had arranged to see [Mr A] at an early postoperative visit.

Typically patients following uneventful surgery would not be seen for a month following the surgery and I believe because [Dr B] arranged for [Mr A] to return some two weeks later this is an indication that Dr B was adopting a conservative and safe approach.

Furthermore the fact that [Mr A] returned on the 8.11.04 reporting a pain and a red blob in his vision means that the communication routes were open and accessible.

What are the likely causes of the tears in [Mr A's] retina? Is it more likely or less likely they would have been caused by needle injury during that surgery?

In my opinion needle stick injuries to the eye using peribulbar or retro-bulbar anaesthesia occur at a higher rate than sub-tenons or topical anaesthesia for cataract surgery. The type of retinal break that occurs during needle stick injury is often typical, i.e. there is evidence of scleral penetration with a golf divot-like break or tear to the retina.

Upon reading [Dr D's] notes, where he described the retinal breaks being linear, this is highly suggestive that a needle stick injury caused this injury.

There is some confusion by [Dr D] as to whether this needle stick injury occurred during the first or second surgery. [Dr D] thought this occurred at the second surgery. However, it was the primary surgery which was performed under local anaesthesia, and [Dr B] is correct in stating the second surgery was performed under general anaesthesia, and the chance of a needle stick injury occurring at the second surgery was extremely remote and can be discounted in my opinion.

Should any other investigations or tests have been ordered by [Dr B] following the surgery of 1 November 2004, prior to the referral made on 11 March 2005?

In my opinion [Dr B] should have ordered an ultrasound to exclude the possibility of a retinal tear and/or retinal detachment.

I appreciate this piece of equipment is not available in [the provincial hospital] but in my opinion arrangements should have been made to an adjacent DHB […].

In the clinical setting where there has been complications following cataract surgery in the presence of low intraocular pressure and vitreous haemorrhage, a retinal break and/or retinal detachment have to be regularly assessed.

Were the services provided by [Dr B] to [Mr A] during the surgery of 9 November 2004 of an appropriate standard and timely?

In my opinion the services provided by [Dr B] to [Mr A] during the surgery of 9.11.04 were of an appropriate standard and timely.

I believe choosing a general anaesthetic indicated that [Dr B] was aware that the surgery might likely be difficult and indeed he planned for a query anterior vitrectomy during this surgical intervention, although this was not required.

I believe it was appropriate to remove the intraocular lens at this stage, as it was subluxed.

[Dr B] noted at this stage there was vitreous haemorrhage and, whilst the evidence points towards a needle stick injury as being the cause of this haemorrhage, in my opinion [Dr B] has not unreasonably suggested that the haemorrhage may have been secondary to the haptic injuring the intraocular structures.

However, as the capsule is avascular, it is not possible that the haemorrhage could have come from rupturing the posterior capsule and that if a needle stick injury had not already occurred in the primary surgery then it is certainly possible that a haptic would have injured the retina at the time of extracting the intraocular lens.

Following the surgery on the 9.11.04 [Dr B] wrote to [Mr A's] family doctor and saw [Mr A] regularly in the month of November.

The intraocular pressure however remained low throughout the month of November and a low-pressure recording was also documented in December 2004.

In my opinion this, together with the very poor acuity in [Mr A's] eye, should have alerted [Dr B] to the fact there was a high chance of him having a retinal detachment at this stage. I believe it would have been a reasonable and appropriate option to refer [Mr A] at this stage for an ultrasound.

Was the referral of 11 March 2005 made in a timely and appropriate manner?

I believe the referral was not timely and that an earlier referral should have been made.

Are the clinical records of an appropriate standard? If not, why not?

I believe the majority of the clinical records are of an appropriate standard but I believe that visual acuities should have been recorded at all postoperative visits, especially when there is an adverse outcome. Furthermore I think it would have

been appropriate for the clinical records to have been signed by the medical or nursing personnel who made that specific entry.

If [Mr A's] version of events is accurate, please explain where that version may lead to any alternative viewpoints for your review.

I believe [Mr A] was concerned by the discrepancy in whether he had been seen by [Dr B] on the 2.11.04. I believe the records support [Mr A's] view on this, although there is no clinical documentation by [Dr B] that he saw him on this date. However, as I have already stated the two subsequent letters written by [Dr B] support [Mr A's] view that he was indeed seen on the 2.11.04.

[Mr A] comments that he had no vision in his eye on 3.11.04 although [Dr B] records a count fingers vision in the left eye.

It is not uncommon for a patient to report no vision in his eye when the vision in his/her eye is as reduced as this. Furthermore, in [Mr A's] version of events, he notes on the first postoperative day 'I had no vision whatsoever in my eye. I could only see a dark colour.' This implies to me that he did have vision in his left eye although it was grossly reduced.

In my opinion [Mr A's] version regarding the sneezing in relationship to his loss of vision is not important; in the sense that sneezing could not cause the problems that Mr A experienced.

Avoiding sneezing was important in patients undergoing cataract surgery who had had a wide incision into the eye. This was typical of surgery performed some 10–15 years ago, namely extra-capsular surgery.

For the micro-surgical incision approach as used by [Dr B], namely associated with phacoemulsification, sneezing is not important and, in my opinion, would not dislocate his intraocular lens.

Sneezing in an eye that has had wide incision cataract surgery can lead to iris prolapse and indeed could in the worst case scenario cause dislocation of the intraocular lens, but this in my opinion is so remote with phacoemulsification that it can be discounted.

Sneezing can induce a vitreous haemorrhage which is called a Valsalva haemorrhage in certain individuals, and whilst this may have been a possibility with [Mr A], I think this would only occur in the clinical setting, i.e. immediately following cataract surgery. In the case of low intraocular pressure this excludes a Valsalva haemorrhage as the cause of [Mr A's] vitreous haemorrhage.

In summary, I believe the sneezing has been over-emphasised and I do not believe it is important in the management and/or outcome of [Mr A's] ophthalmic problems.

[Mr A] raises the concern regarding the vitreous haemorrhage and subluxed intraocular lens.

Referring to the clinical notes made by [Dr B], this is perhaps less important than [Mr A] believes. [Dr B] notes that the vitreous haemorrhage and subluxed intraocular lens was present on the 8.11.04 and had not been present on 3.11.04.

In my opinion the subluxation is likely to occur between these two dates, and elective surgery planned for the following day was timely and appropriate. I do not think it was necessary to remove the intraocular lens acutely on the 8.11.04.

As to [Mr A's] concern as to whether the haptic may have caused the vitreous haemorrhage, I have already alluded to this as a possibility, but I think it is unlikely.

What standards apply in this case?

I believe the standards for patients undergoing cataract surgery in NZ should be high and the protocols developed by [the provincial hospital] are of a high standard. I believe the surgery performed by [Dr B] was also of a high standard, and his surgical intervention was appropriate.

I believe however [Dr B] failed [Mr A] in arranging to perform an ultrasound in the perioperative period following the second surgery. I appreciate that [the provincial hospital] did not have a diagnostic ultrasound machine available and that not all patients with vitreous haemorrhage need an ultrasound.

However I believe in this clinical setting [Mr A] should have had an ultrasound performed preferably in the first week or two following the second surgery.

One alternative, which [Dr B] does not appear to have considered, is of hospitalising [Mr A] and placing him on bed rest to see if the haemorrhage would clear sufficiently for him to have an adequate view of the retina.

I believe that if [Dr B] had done this he may well have been able to visualise the retina and detect the retinal breaks prior to the retinal detachment. However, if the blood had not cleared sufficiently for [Dr B] to see [Mr A's left retina then arrangements should have been made for a referral to either [the city hospital], or an adjacent public hospital facility.

I note that in [Dr B's] review of [Mr A's] management that he recognises this and that they have reviewed their policies regarding this scenario and have adapted their protocols accordingly.

Furthermore I understand [Dr B] is reviewing the type of regional anaesthesia used for cataract surgery.

There is evidence to suggest that intraocular perforations are more common with retrobulbar and peribulbar anesthesia than topical or subtenons anesthesia. Having said that, in experienced hands peribulbar anesthesia is of low risk and I believe [Dr B's] experience would support this.

Furthermore topical anesthesia tends to score more poorly in terms of patient's satisfaction and can make the surgery more difficult with a higher risk of complications as the extraocular eye muscles are not paralyzed with this approach.

The recognition of vitreous haemorrhage in [Mr A's] left eye following the second surgery should have prompted [Dr B], if he was unable to view the retina, to perform ultrasound.

I appreciate this diagnostic instrument was not available in [the provincial hospital] but an alternative option would have been for [Dr B] to admit [Mr A] to hospital and place him on bed rest. This, under some circumstances, will allow the vitreous haemorrhage to clear sufficiently that the retina can be visualized.

However, yet another option would have been to arrange a diagnostic ultrasound and I believe a timely referral to either [the city hospital], or an adjacent public hospital facility, where this instrument was available should have been undertaken.

I believe it is not an appropriate standard to instruct a patient to report the development of entoptic phenomenon as an indication of retinal detachment, especially in this setting, where the patient already had already significantly compromised vision and low intraocular pressure following recent cataract surgery.

I would therefore assess the departure from normal standards would be moderate. I think [Dr B] attempted to trust his ability to diagnose a retinal detachment from clinical signs when regrettably this was not possible."

Responses to the provisional opinion

Mr A
Mr A responded to the provisional opinion by reiterating a number of factual inconsistencies between his and Dr B's recollections. He concluded:

"In conclusion I wish to express my grave concern at the inaccuracies that are recorded in the medical records relating to my eye."

Dr B
Dr B responded to the provisional opinion as follows:

"I consider that it is fair and that in retrospect I should have referred [Mr A] to a Tertiary Hospital sooner. Being the only specialist in a provincial hospital and trying to cope with the volume of work, as well as 24/7 on call duties for the past eight years, makes it difficult at times to record events.

…

The confusion caused by not signing my notes or not fully recording events, is very obvious to me, and was a very good object lesson.

…

It seems a pity that one should be guilty of breaching Right 4(2) of the Code at the end of one's career, but on the other hand as I indicated in my letter of apology to [Mr A], there have been enormous benefits to our practice as a result of his complaint. My staff have been kept fully informed and I have their wholehearted support in all efforts to 'get it right'.

Concerning your proposed recommendations:

1) Letter of apology to [Mr A] is enclosed.

2) As can be seen a total review of our practice was done and is completed.

3) I will remind the CEO of [the DHB] to write a letter of apology to [Mr A].

4) When I accepted the post as ophthalmologist at [the hospital] a full assessment of my practice and qualifications was done by an external review. I believe the assessors came from Australia.

5) … I wrote to the Vitreo Retinal surgeons [at the city hospital] on referrals of cases with vitreous haemorrhages, and I got a reply showing their willingness to see cases immediately. The hospital is having difficulty in providing full ultrasounds at all times, but I have requested and been given the assurance that ultrasound in vitreous haemorrhages will be considered as 'Urgent'.

The District Health Board

The District Health Board advised that it has reminded staff in the Eye Clinic of their responsibility to keep accurate and contemporaneous records. The documentation will be periodically reviewed to ensure appropriate practice is maintained.

The Board has two ultrasound scanners available for ophthalmology purposes. The protocol for their use is established. However, the Board will ensure clinicians are aware of processes required to access the equipment efficiently.

The Board has reviewed Dr B's practice, in addition to the competence review undertaken by the Medical Council of New Zealand.

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.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

Professional Standards

Good Medical Practice:[3]

> "Keep clear, accurate, and contemporaneous patient records that report the relevant clinical findings, the decisions made, the information given to patients, and any drugs or other treatment prescribed."

[3] Medical Council of New Zealand: *Good Medical Practice — A guide for doctors* (October 2004).

Opinion: Breach — Dr B

Mr A is concerned that the surgical services and postoperative care provided by Dr B were not of an acceptable standard, that Dr B did not refer him to Dr D for surgery in a timely manner, and that the delay significantly affected his vision. When Mr A reviewed his medical notes he found some discrepancies in Dr B's documentation.

Under the Code of Health and Disability Services Consumers' Rights ("the Code") Mr A had the right to receive services of an appropriate standard. My independent expert ophthalmologist, Dr Polkinghorne, has reviewed this case and advises that the surgical services were of an appropriate standard.

Dr Polkinghorne has criticised aspects of the postoperative care, notably the lateness of the referral to Dr D. Having reviewed the available information and Dr Polkinghorne's comments, I consider that the delay in referring Mr A to Dr D was unacceptable. In this respect, Dr B did not provide Mr A with care of an appropriate standard, and breached Right 4(1) of the Code.

Dr B was required to keep clear and accurate records. During the investigation I found several discrepancies and errors in Dr B's documentation. In this respect Dr B also breached Right 4(2) of the Code in failing to provide services that comply with professional standards. The reasons for my decisions are given in more detail below.

Surgery on 1 November 2004
Dr D suggested that the local anaesthetic injection given by Dr B may have caused an injury to Mr A's eye, which resulted in a haemorrhage and consequential damage to the retina.

Dr B provided details about the procedure and suggested that there may be other causes for the haemorrhage. Dr Polkinghorne commented that in his opinion "[Dr B] has not unreasonably suggested that the haemorrhage may have been secondary to the haptic injuring the intraocular structures". It appears that the tears may have occurred during the tactile aspects of the surgery.

I accept Dr Polkinghorne's advice that the procedure was correct and performed with the necessary skill and expertise. In my opinion both the surgery and the local anaesthetic were of an appropriate standard and Dr B did not breach the Code in this regard.

Dr Polkinghorne also advised that the care provided by Ms C in Dr B's absence was appropriate to Mr A's needs. Mr A required an ophthalmologist's review within a day or two of surgery, for a full assessment. It was reasonable for Dr B to examine Mr A on 3 November. It is unnecessary to determine whether the first postoperative examination by Dr B was conducted on 2 or 3 November, since an examination on either date would have been adequate.

Mr A is concerned about the comments made by Dr B about sneezing. Dr B has apologised for any misunderstanding, and Dr Polkinghorne notes that sneezing could not cause the problems Mr A experienced — the haemorrhage may have occurred for a number of reasons. It appears that the sneezing issue is a red herring.

Surgery on 9 November 2004
Mr A required emergency surgery on 9 November to address complications from the surgery eight days earlier. Dr B removed the intraocular lens and confirmed that a haemorrhage had occurred.

Dr Polkinghorne advised that the management and surgery on 9 November was of an appropriate standard. Accordingly, Dr B did not breach the Code in this regard.

Care and treatment following 9 November surgery
Review of the care and treatment provided after the second surgery has highlighted some concerns. Dr Polkinghorne advised that Dr B should have considered a diagnostic ultrasound scan "preferably in the first week or two following the second surgery". He might also have considered hospitalising Mr A to see if bed rest would afford an improved view of the retina.

Dr Polkinghorne commented on Dr B's management strategy "to instruct [Mr A] to report the development of entoptic phenomenon as an indication of retinal detachment …". This was not acceptable because of Mr A's "already significantly compromised vision and low intraocular pressure following recent cataract surgery".

I accept Dr Polkinghorne's advice that Dr B confined his review of Mr A's care to a limited range of clinical observations. The more appropriate pathway was to do an ultrasound scan in late November when the intraocular pressures remained low and the visual acuities were poor. This would have alerted Dr B to the problem of a detached retina much sooner, and a more timely referral could have been made to Dr D.

Dr B did not consider referring Mr A for a diagnostic ultrasound or advising bed rest. He believed it was reasonable to wait for the hemorrhaged blood to absorb. He also relied on Mr A's ability to observe changes in his vision.

In my opinion, Dr B should have referred Mr A for a diagnostic ultrasound within two weeks of his second surgery, when his eye had not cleared; Dr B should certainly not have delayed for three months before referring Mr A to a vitreoretinal surgeon. The practical difficulties (the lack of appropriate ultrasound equipment at the provincial hospital, and the intervening Christmas period) do not excuse Dr B's lax approach to managing Mr A's ongoing problems with his eyesight. Patients rely on their specialists to be responsive to their needs and to be proactive (including referral for further specialist input, if indicated) when postoperative complications do not resolve within a reasonable time.

In these circumstances, Dr B did not provide postoperative care of an appropriate standard and breached Right 4(1) of the Code.

Record-keeping and clinical documentation
There are a number of discrepancies and errors in Mr A's medical records. In particular, I note:

- There are errors in Dr B's letter to his colleague on 10 November, where he describes an examination of the fundal view on "the first day post-operatively". The records show that Mr A was seen only by Ms C on the first postoperative day.

- Dr B wrote to a vitreoretinal surgeon on on 11 March 2005. Dr B recorded the date of the first surgery as 3 November, instead of 1 November. Again, Dr B refers to his first postoperative assessment as "the following day".

- The reference to Mr A sneezing when he denies having made this comment to Dr B.

- The unsigned and unidentified note in Mr A's medical records on 2 November about a call being made to the Emergency Department.

- There is no contemporaneous discharge letter after the cataract surgery, contrary to expected practice for a surgeon.

- Many of the entries made in the medical records are unsigned, undated, and contain no designation of the health provider.

Some of these records are obviously inaccurate in recording events. This has led to confusion about when examinations took place and who completed them. Mr A himself noted some discrepancies in the clinical documentation. This has adversely affected his relationship with Dr B.

In my opinion, Dr B did not fulfil professional standards for a doctor, as required by the Medical Council of New Zealand. In these circumstances he breached Right 4(2) of the Code.

Opinion: Breach — The District Health Board

Vicarious liability
Dr B is an employee of the District Heath Board. Section 72(2) of the Health and Disability Commissioner Act 1994 provides that anything done or omitted by a person as the employee of an employing authority shall be treated as done or omitted by that

employing authority as well as by the employee, whether or not it was done or omitted with that employing authority's knowledge or approval. Section 72(5) of the Act provides a defence from such liability if the employing agency can show that it took reasonable and practical steps to prevent the events from occurring.

Although the DHB had appropriate record-keeping policies and cataract surgery protocols in place, I have received no evidence of the steps the Board took to ensure that Dr B was competent and that his services (including this postoperative management of cataract patients) were of an appropriate standard. Nor have I received any evidence to show what steps the DHB took to improve the quality of Dr B's records — even though it must have been obvious to his clinical colleagues at the provincial hospital that his notes were significantly deficient.

In these circumstances, the Board is vicariously liable for Dr B's breach of Right 4(1) of the Code.

Recommendation

The District Health Board
I recommend that the District Health Board provide a written apology to Mr A for its breach of the Code. This apology should be sent to the Commissioner and will be forwarded to Mr A.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand and the Royal Australian and New Zealand College of Ophthalmologists.

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