Ophthalmologist, Dr B

Southland District Health Board

A Report by the

Health and Disability Commissioner

(Case 06HDC15893)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer
Mrs A	Complainant/Consumer's wife
Dr B	Provider/Ophthalmologist
Dr C	Ophthalmologist
Dr D	General practitioner
Dr E	Ophthalmologist
Dr F	Ophthalmologist
Southland District Health Board	Provider

Complaint and investigation

On 31 October 2006, the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her husband, Mr A, by an ophthalmologist, Dr B. The following issues were identified for investigation:

- *The appropriateness of the care provided to Mr A by Dr B from 24 November 2004 to June 2006.*
- *The appropriateness of the care provided to Mr A by Southland District Health Board from 24 November 2004 to June 2006.*

An investigation was commenced on 27 April 2007. This investigation took over 12 months to complete because of the complex issues involved, and because of delays arising from unsuccessful challenges by Dr B's lawyer (including a complaint to the Office of the Ombudsmen).

Independent expert advice was obtained from ophthalmologist Dr Philip Polkinghorne (see appendices A and B).

Information gathered during investigation

Overview

In November 2004, 57-year-old Mr A was referred to Southland Hospital ophthalmology clinic by his general practitioner, Dr D, with a painful eye and reduced vision. At this time, Mr A reported being otherwise healthy apart from partial deafness. He saw Dr B, ophthalmologist, on seven occasions over the next 16 months with episodes of sore eyes and reduced vision.

Names have been removed (except Southland Hospital/Southland DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In May 2006, Mr A presented to Dr B with severely reduced vision. Dr B diagnosed him with glaucoma and arranged an appointment for the next week to investigate further. Unfortunately, that clinic was cancelled and Mr A did not receive any further care from the ophthalmology clinic until his vision deteriorated and his wife contacted the hospital six weeks later. On 21 June 2006 Mr A saw a locum ophthalmologist, who found that he was almost blind. Mr A underwent urgent glaucoma drainage surgery on each eye and was investigated for systemic disease. These investigations revealed widespread low-grade B cell lymphoma. Mr A is now blind.

Treatment of Mr A's eye problems

Initial presentation — iritis

Dr B first saw Mr A on 24 November 2004, after Dr D referred him acutely to the Southland Hospital ophthalmology clinic (the Eye Clinic). Mr A presented with a one-month history of a "red aching left eye" and reduced vision. Dr B took an ophthalmic, social and general medical history, and diagnosed moderately severe iritis[1] in Mr A's left eye, and mild iritis in his right eye. Dr B prescribed Maxidex[2] and Cyclogyl[3] drops. In response to a specific request from HDC, Dr B stated that he had also measured Mr A's intraocular pressure.[4] Dr B said:

> "I have no doubt that I measured [Mr A's] intraocular pressure when he presented [on 24 November 2004]. That is my standard routine practice; it is something I always do almost automatically, as a routine part of examining a new patient and, if the pressures were raised, I have no doubt that would have been recorded. That it was not documented in either his notes or correspondence on that day indicates to me that it must have been normal."

However, there is no documentation in the notes to indicate that Dr B measured Mr A's intraocular pressure at this appointment. Dr B noted that, while he "would normally write down even a *normal* intraocular pressure", he did not in this case as the limitations imposed by the unsafe working environment and the acute physical disability he was suffering from at the time did not allow sufficient time to write thorough clinical notes.

Dr B stated that the fact that the measurement was not written in Mr A's notes could be explained by:

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[1] Inflammation of the iris.

[2] Maxidex drops contain a steroid to treat inflammation.

[3] Cyclogyl drops contain cyclopentolate hydrochloride to dilate the pupil.

[4] Intraocular pressure is the pressure of fluids in the eye. It is most commonly measured by placing a local anaesthetic drop into the eye, then placing a tonometer against the anaesthetised cornea. The tonometer measures the intraocular pressure in millimetres of mercury (mmHg), and is considered raised if above 21 mmHg. Raised intraocular pressure over time causes damage to the optic nerves, and can result in a loss of vision.

1. physical limitations of the clinic, including a darkened room which meant that he was unable to see his clinic page to write down his findings during the examination;

2. his own acute physical disability which reduced his ability to move around the examination room;[5]

3. Mr A's deafness, which meant that Dr B had to remain close to Mr A to communicate, when he would ordinarily be writing clinical notes;

4. time pressures, particularly resulting from having to take patients in and out of the room himself and accommodating acute cases (such as Mr A).

Mr and Mrs A also believe that Mr A's intraocular pressure was measured at his initial appointment. Therefore I accept it is likely that Dr B did measure Mr A's intraocular pressure at the appointment on 24 November 2004.

Dr B communicated his findings in a letter to Mr A's GP, Dr D, and ordered a follow-up appointment on 1 December 2004.

On 1 December, the Eye Clinic secretary telephoned Mrs A to advise that her husband's appointment had been cancelled because Dr B was unwell. Mrs A was advised to go to the Emergency Department if she was concerned, and another appointment was arranged for one week later. On 8 December, Mr A returned for his follow-up appointment. His iritis had not resolved, so Dr B instructed Mr A to continue with the Maxidex drops, and to return in a fortnight.

Mr A returned on 22 December, and Dr B found that the iritis was improving. Dr B prescribed a reduced regimen of Maxidex drops for another fortnight, and discontinued the Cyclogyl drops. Mr A returned on 20 January 2005, to "check that all is well on no treatment" after taking no medication for two to three weeks. Dr B was satisfied that Mr A did not require further treatment, so discharged him to Dr D's care.

Second presentation — iritis

On 29 June 2005, Mrs A contacted the Eye Clinic secretary to report that her husband had "a flare-up" and requested advice on what to do. The Eye Clinic secretary faxed this request to Dr B at his private rooms. Dr B recommended that Mr A see his GP. Dr D arranged an Eye Clinic appointment for Mr A on 13 July.

At the appointment on 13 July, Mr A reported a two-week history of discomfort in both eyes, for which Dr D had prescribed Maxidex. Dr B noted a mild recurrence of Mr A's iritis and instructed him to continue with the Maxidex for 17 days. In a letter to Dr D dated 18 July, Dr B wrote: "On examination today he has the occasional cell in

[5] Dr B explained that he had an acute orthopaedic disability at that time, which caused him pain and reduced his ability to move about the examination room.

each anterior chamber but things are looking pretty good over all." Dr B could not be sure whether he measured Mr A's intraocular pressure in July 2005. It is not documented in the clinical notes. Mr and Mrs A do not recall Dr B measuring Mr A's intraocular pressure at this appointment.

Although Dr B did not order a follow-up appointment, Mr A was "accidentally" given an appointment for 27 July 2005 (according to Dr B's letter to Mr A's GP dated 27 July). On 27 July, Dr B found mild iritis in both eyes and asked Mr A to recommence Maxidex drops for a fortnight, when he would be reviewed at a follow-up appointment. Again, Dr B informed Dr D of his findings.

According to Mr A's notes and his letter to Dr D, Dr B ordered a follow-up appointment for two weeks' time. However, Mr A was not seen again until 2006. SDHB explained that the Eye Clinic secretary made an appointment for 17 August 2005, but it was cancelled by Mr A on 16 August.[6] However, Dr B stated that, although the Eye Clinic secretary noted in Mr A's record that he was to be seen in two weeks, no appointment was made. Mrs A stated that neither she nor her husband ever received notice of an appointment in August 2005, and that neither of them had ever cancelled an appointment with the Eye Clinic. There is no record of any attempts to re-book Mr A another appointment after the 17 August appointment was cancelled.

Third presentation — glaucoma, raised intraocular pressure

Mr A next saw Dr B on 10 May 2006, when he presented with a one-month history of reduced vision. Dr B noted that Mr A had raised intraocular pressures, which were recorded at 44mmHg in both the right and left eyes.[7] Dr B prescribed Xalatan[8] and Timolol,[9] and ordered a follow-up appointment in one week's time. Dr B communicated these findings to Dr D, also noting that Mr A had cupped optic discs, and recorded a diagnosis of glaucoma.[10]

Although Mr A was booked to see Dr B on 17 May, this clinic was cancelled, apparently in the mistaken belief that Dr B would be overseas. A letter dated 15 May from the Eye Clinic Secretary was sent to Mr A, explaining that the clinic was cancelled owing to Dr B being overseas and stating that "I will re-schedule your appointment and send you a letter with a new appointment date and time". Dr B was not in fact overseas on 17 May, and arrived expecting to undertake his clinic that day, only to find that it had been cancelled.

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[6] SDHB provided a printout of the IBA patient management system recording that Mr A's appointment on 17 August 2005 was cancelled at the patient's request.

[7] Optimum intraocular pressure is between 15–20 mmHg (see further expert advice in Appendix A).

[8] Xalatan drops reduce intraocular pressure in patients with glaucoma or ocular hypertension.

[9] Timolol drops also reduce intraocular pressure.

[10] Glaucoma is an eye disease characterised by an increase in intraocular pressure, which causes damage to the optic disc and reduces the visual field.

Mr A's appointment was apparently supposed to be rescheduled for 24 May but he was never advised of a rescheduled appointment. According to a note on a printout of the Day Clinic List for 17 May, a letter advising of a rescheduled appointment was sent after three attempts to contact Mr A by telephone. However, the only letter on Mr A's clinical file is the 15 May letter, which advised him that a new appointment would be arranged. A handwritten entry in Mr A's notes, next to a date stamp for 24 May 2006, states "cxld clinic". Mr A's appointment time for 24 May was subsequently allocated to another patient. There is no record of any attempt to re-book Mr A in a later clinic. SDHB advised HDC that the reason for this was that Dr B was on leave from 19 to 28 May (excluding 24 May), which was then extended until 25 June.

Dr B stated:

> "I have on numerous occasions over many years, written to and talked to management about my concerns regarding appointments not being made and there being no systems in place to ensure this did not happen … [Mr A] was lost to follow-up, despite clear instructions from me that he required further assessment."

Dr B advised that in addition to documenting when follow-up appointments are to be made in a patient's clinical notes, he verbally told the clinic nurse and wrote it on the copy of the clinic sheet that went to the Eye Clinic secretary (for booking follow-up appointments) at the end of each clinic. Dr B advised that he included any intended follow-up when dictating letters after seeing patients, adding emphasis where follow-up was urgent, and also told patients to telephone the ophthalmology department if they did not receive confirmation that they were booked into an appointment close to the expected appointment date.

Fourth presentation — severe glaucoma, raised intraocular pressure, bilateral uveitis[11]

On 19 June 2006 Mrs A telephoned the ophthalmology department to advise that her husband needed an appointment, after he had contacted her at work that day saying he could not see. An appointment was arranged for 21 June, and Mr A was seen by locum ophthalmologist Dr C. Dr C found Mr A to be almost blind from glaucoma, with very high intraocular pressures of 50mmHg in each eye, and bilateral uveitis. Dr C commenced Diamox[12] to lower Mr A's intraocular pressures, and communicated his findings to Mr A's GP.

Subsequent treatment and diagnoses

On 23 June Dr C performed glaucoma drainage surgery on Mr A's right eye followed by his left eye five days later. Although intraocular pressure in both eyes was low

[11] Inflammation of the uveal tract.

[12] Diamox inhibits fluid secretion, and is suitable for treatment of glaucoma associated with raised intraocular pressure.

postoperatively, by 18 July Mr A's intraocular pressures were in the normal range and his uveitis had resolved.

Mr A's vision is still significantly impaired, and he is registered as a member of the New Zealand Foundation of the Blind. In addition, subsequent investigations at another district health board revealed widespread low grade B cell lymphoma.[13]

Relevant context

Southland DHB
Correspondence between SDHB and Dr B indicates that Dr B had a difficult relationship with administrative staff at the ophthalmology department and SDHB management over many years. In a letter to Dr B dictated 25 September 2006, SDHB Chief Operating Officer noted that Dr B had a "tendency to blame administrative staff for any shortcomings in the service" and that five different secretaries had left the department within five years, which was "very unusual within the hospital". According to the Chief Operating Officer, "most of those leaving will indicate that they found working with [Dr B] to be very challenging", which made it "extremely difficult to recruit" staff. The Chief Operating Officer also noted that no other ophthalmologist who had used the Eye Clinic rooms in the new hospital had complained about the design.

SDHB advised that, subsequent to the problems in Mr A's bookings with the Eye Clinic, "we have since reviewed the administration of the Eye Department and made significant changes to prevent this type of occurrence happening again". SDHB advised of specific changes within the ophthalmology department, which included: Dr B's resignation from 31 March 2007, and the appointment of two new full-time ophthalmologists; other improvements related to increased administrative support; and improved links with another District Health Board's ophthalmology department.

Dr B
Dr B complained to SDHB on 10 November 2004 regarding his concerns about the lighting arrangement in the ophthalmology department:

> "It is unsatisfactory that I still do not have a light switch to use during a clinic. ... At present it is unsafe for me to have to walk through a darkened room on many occasions over each clinic"

Dr B complained again on 14 December 2004:

> "The layout and design of the new [ophthalmology] clinic, as well as the absence of dimmers and the absence of a light switch at the end of the clinic makes adequate examination of my patients difficult, and has slowed

[13] Cancer of the lymphatic system, involving malignant transformations of B-lymphocytes.

> considerably the throughput of patients. This raises two concerns, firstly that of patient safety,[14] which is the overwhelming and most important issue, and secondly, that of patient satisfaction as there will be a backlog created by the inadequate working environment."

Dr B advised that, although the number of appointment spaces for his SDHB clinics were reduced to allow for acute patients, and the lighting was improved in the consulting rooms, he remained frustrated and concerned by administrative procedures. This resulted in overbooked clinics, missed bookings and poor follow-up of patients. However, in his letter to SDHB on 14 December 2004, Dr B noted that there had been "some practical resolution" along the lines he had suggested, and his request for further change related to the lighting in the consultation room.

In a letter to SDHB dated 31 August 2006 responding to concerns raised about his care of Mr A, Dr B wrote:

> "Southland Hospital will be aware of the number of occasions that I have raised issues relating to the lack of efficient and competent administration staffing at the Southland eye clinic. This concern is illustrated by the [number of] times [Mr A] was lost to follow-up, despite clear directions from me that he required further assessment."

In a subsequent letter, dated 18 September 2006, Dr B stated:

> "I am very sorry that [Mrs A] *may perceive* that I made a mistake, or was negligent, or that any actions of mine have led to concerns on behalf of her husband or family" (italics added).

Dr B did not send an apology to Mr and Mrs A. Dr B resigned from SDHB on 31 March 2007.

Medical Council of New Zealand

The Council undertook a review of Dr B's competence in October 2007. The Council considered that Dr B met the required standard of competence but resolved that he be required to provide evidence to the Council of certain professional development activities.

[14] It is relevant to note that Dr B had raised patient safety concerns on previous occasions. However, in a High Court judgment, in relation to Dr B's claim that contracting a visiting Australian ophthalmologist would jeopardise patient safety, stated: "The submission … that Dr B was concerned about patient safety ... was a rationalisation, and a convenient excuse to secure support to protect his position."

Response to Provisional Opinion

The majority of the parties' comments on my provisional opinion have been dealt with by amendments to the text. Remaining comments are outlined below:

Southland District Health Board
SDHB accepted that there were problems within the ophthalmology department at the time of Mr A's treatment, and reiterated previous assurances that these problems have been resolved. SDHB expressed willingness to arrange an independent audit of the ophthalmology department.

SDHB did not agree with Dr B's claims that his work environment was unsafe, and advised that management were not aware of Dr B's acute orthopaedic disability. SDHB noted that Dr B raised issues of patient safety for the first time on 14 December 2004 and stated:

> "[I]t can be seen that [Dr B] has once again sought to raise patient safety as a 'convenient excuse' when faced with possible disciplinary action. Had that truly been his first and foremost concern one would have expected it to have featured in his [10] November [20]04 Memorandum."

SDHB advised that Dr B had never mentioned any difficulties in making notes due to the darkness in the room, despite citing this as a major issue during this investigation.

SDHB also did not agree with Dr B's assertion that his documentation suffered because of time pressure created by taking patients in and out of the room himself, and fitting in acute cases. SDHB stated:

> "It is ... not correct that [Dr B] was required to take patients in and out of the clinic. [Dr B] always had a nurse available who amongst other duties takes patients in and out of the room.
>
> …
>
> The time pressures [Dr B] refers to are difficult to fathom … [I]t is [Dr B] who [controlled] the timing and sequence of the clinics himself and could easily schedule administrative time [to complete patient records] if required. Acute presentations … would have been infrequent interruptions to clinic time."

Dr B
Dr B was critical of the ophthalmology administrative staff for not contacting him on 19 June 2006 when Mrs A reported that her husband "could not see". Dr B stated that he would have promptly attended Mr A if he had been alerted to his sudden deterioration, and regretted that Mr A had to wait two days for an emergency appointment to see Dr C. Dr B noted that on 29 June 2005, the previous Eye Clinic

secretary had contacted him at his private rooms regarding Mr A, and he had promptly provided advice via facsimile.

Dr B stated, in November 2007, that from his current perspective of practising in a private clinic in Invercargill, the administrative problems that existed in the ophthalmology department at the time of Mr A's treatment continue to exist. Dr B advised:

> "I continue to see delays in important appointments being made and a number of patients are still transferring to my [private] rooms after frustration waiting for overdue appointments at Southland Hospital. … The secretarial department … was and still is … inefficient and failing to make appointments."

Independent advice to Commissioner

Expert advice was obtained from ophthalmologist Dr Philip Polkinghorne, who was asked to comment on the standard of care provided to Mr A by Dr B from 24 November 2004 to June 2006. This advice is set out in Appendix A.

I also asked Dr Polkinghorne to provide additional expert advice after receiving Dr B's response to my provisional opinion. This advice is set out in Appendix B.

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.

...

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

The Medical Council of New Zealand's *Good Medical Practice — A guide for doctors* (2004) states that in providing care a doctor must:

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

Opinion: Breach — Dr B

Standard of care

Dr B saw Mr A on seven occasions between 24 November 2004 and 10 May 2006. In my opinion, by failing to regularly measure Mr A's intraocular pressure and to document his findings, Dr B did not provide Mr A with an appropriate standard of care.

Intraocular pressures

Dr B did not document any measurement of Mr A's intraocular pressures until May 2006, when the pressures were recorded at 44mmHg in both the right and left eye. My expert, Dr Polkinghorne, advised that "measurement of intraocular pressure is a normal part of most ophthalmic examinations", and in this case should have been checked "at every visit or at least every second visit". Raised intraocular pressure is an indicator of glaucoma, and can result in a loss of vision.

Dr B maintains that he measured Mr A's intraocular pressures at the initial appointment on 24 November 2004, although there is no record in Mr A's notes of intraocular pressure at this appointment. Dr B explained that it is his standard practice to measure the intraocular pressures of new patients. He stated that although he would normally write down "even a normal intraocular pressure", he did not do so in this case because of the limitations imposed by his unsafe working environment and his acute physical disability did not allow sufficient time to write thorough clinical notes.

Sketchy consultation notes make it difficult to confirm the facts of a case, and tend to throw suspicion on any supplemental information provided. In the end, whatever is remembered at a later date, the written record is the most significant witness of a provider's actions. It is important for the provider's sake as well as the patient's that there is a clear and complete record. Dr B's poor documentation of the care he provided to Mr A (discussed below) has made it difficult to determine whether he provided an appropriate standard of care.

Dr B's recollection that he measured Mr A's intraocular pressure on 24 November 2004 is supported by Mr and Mrs A's accounts of this appointment. Given Mr and Mrs A's recollection, and Dr B's evidence that it is his standard practice to measure intraocular pressures at first presentation, I consider it more likely than not that Dr B carried out this examination. Therefore I accept that Dr B did measure Mr A's intraocular pressure at this appointment, but failed to document his findings.

However, there is no evidence that Dr B measured Mr A's intraocular pressures again until 10 May 2006, despite seeing him on five separate occasions in the intervening period.

In relation to this issue, Dr Polkinghorne, advised:

> "[W]ith an intraocular problem, especially in view of a ... history of appointments not being kept or made it would not be unreasonable to check [intraocular] pressures at every visit or at least every second visit."

I accept this advice and conclude that Dr B should have measured Mr A's intraocular pressures during at least one of the five consultations in the period between 24 November 2004 and 10 May 2006. Dr B commented in his response to my provisional opinion: "I do not accept that it was mandatory to check [Mr A's] intraocular pressure '*at every visit, or at least every second visit.*'". In my view, the failure to record any measurement of Mr A's intraocular pressures from 24 November to 10 May 2006, over six consultations, was not acceptable. Appropriate examination and documentation of Mr A's condition was particularly important given Dr B's knowledge of the problem of patients being lost to follow-up within the SDHB ophthalmology department.

Conclusion
By failing to regularly measure Mr A's intraocular pressures Dr B did not provide Mr A with an appropriate standard of care and therefore breached Right 4(1) of the Code.

Documentation
It is a professional and legal requirement for a practitioner to maintain a clinical record for each patient in accordance with professional and ethical standards. It is essential that all relevant information, including appointments, examinations, and test requests and results, are accurately recorded to guide future management and ensure continuity of care.[15]

Intraocular pressures
As outlined above, although I accept that Dr B measured Mr A's intraocular pressures on 24 November 2004, he did not document this examination in Mr A's notes. Dr Polkinghorne advised:

> "[T]hat not all negative signs are notated during a clinical examination is valid [however] [Mr A's] intraocular pressure was not recorded in the clinical notes [on 24 November 2004] and in my opinion that was and remains an error of judgement ... [T]he absence of any notation of the intraocular pressure until 2006 is unacceptable."

Retinae and optic nerve heads
Although he did not document his findings, Dr B stated that he examined Mr A's retinae and optic nerve heads at both the first consultation on 24 November 2004, and the second consultation on 8 December 2004. Dr B advised that he would have examined Mr A's retinae and optic nerves as a matter of course:

> "My standard practice in examining such patients is to thoroughly examine both the posterior and anterior segments of the eye, at the first presentation.
> ...
> I would have looked at [Mr A's] discs and optic nerves again on [8 December 2004] as a routine matter of course."

In relation to this issue, Dr Polkinghorne advised:

> "[T]he examination of the retina and optic nerve heads should have been undertaken at the second visit [8 December 2004] when the pupils were dilated and the iritis less active. I believe a further examination of the optic discs could have been delayed until May 2006 when the intra-ocular pressure was noted to be elevated."

[15] See also *Cole's Medical Practice in New Zealand* (2005), page 83.

Dr B did record an examination of Mr A's retinae on 10 May 2006, in which he noted a possible preretinal membrane over Mr A's left macular. Dr B also recorded a finding of "cupping of his optic discs" in the letter to Dr D dated 10 May 2006 (although there is no mention of the severity of the cupping). Dr B explained this in his response to my provisional opinion: "I would never use the word '*cupping*' without the appropriate adjective such as '*normal*', '*modest*' or '*gross*' however the letter I dictated ... was never shown to me to correct its errors, and was not signed by me." In my view, this highlights the importance of contemporaneous documentation of key findings in the patient's clinical notes. It was not acceptable to rely on clinical findings being documented only in letters to the patient's GP.

Dr B's explanation
Dr B states that his note-taking is normally meticulous, and he has offered various excuses for failing to appropriately document these important clinical observations.

Dr B's acute physical condition apparently limited the time available to him to make thorough notes. I am also aware that Dr B found his work environment at Southland Hospital to be unacceptable. However, it is not unusual for specialists in public hospitals to be dissatisfied with their working environment. Specialists have a responsibility to take a constructive approach to raising any problems, accepting the inevitable resource constraints in the public system. In any event, these issues, and any management and administrative shortcomings, did not abrogate Dr B's responsibility to keep "clear accurate and contemporaneous patient records that report relevant clinical findings, the decisions made, the information given to patients and any drugs or other treatment prescribed".[16]

Conclusion
Dr B failed to record Mr A's intraocular pressures on 24 November 2004, and the findings from examination of his retinae and optic nerve heads on 24 November and 8 December 2004. Although his examination and findings of 10 May 2006 were partially documented in the letter to Dr D, Dr B did not fully document his assessment in Mr A's clinical record. By these omissions, Dr B failed to provide Mr A with services that complied with professional standards, and breached Right 4(2) of the Code.

As noted by Baragwanath J in *J v Director of Proceedings* (an appeal from a decision of the Health Practitioners Disciplinary Tribunal),[17] "[f]or the reasons expressed by the Tribunal meticulous record keeping is a fundamental obligation of the practitioner". The Tribunal had stated:[18]

[16] Medical Council of New Zealand statement, *Guidelines for the maintenance and retention of patient records* (August 2001).

[17] *J v Director of Proceedings* (High Court Auckland, CIV-2006-404-002188, 17 October 2006).

[18] Health Practitioners Disciplinary Tribunal decision Med05/11D (12 April 2006).

> "... Note-keeping should not be regarded as a minor matter. … Thorough note-taking is the cornerstone of safe and effective medical practice. Poor note-taking provides poor support for clinical practice for either [the practitioner] or any other person reviewing his notes and continuing or amending the treatment plan which has been prescribed."

If the findings from Dr B's examinations had been regularly and clearly recorded, a subsequent review of Mr A's notes may have highlighted subtle but consistent deterioration, and possibly raised a "red flag" to more serious issues.

Summary
In my view, Dr B's care for Mr A was not of an appropriate standard and his documentation was poor. He has been quick to blame administrative staff and management for these inadequacies, and has never apologised to Mr A.

Mr A needed urgent follow-up after seeing Dr B on 10 May 2006 and was booked to see Dr B on 17 May. When that clinic was mistakenly cancelled (through no fault of Dr B), he made no personal effort to follow up Mr A and ensure that he was seen. Instead, he left it to clinic staff to arrange a follow-up appointment and went on leave from 19 to 28 May (excluding 24 May), which was then extended to 25 June. Dr B owed a duty of care to follow up a patient whom he knew to have significant problems (a one-month history of reduced vision and very high intraocular pressure) and to be in urgent need of follow-up, particularly given that he also knew there were administrative problems with booking appointments. As noted by my expert, "had Mr A been seen between 10 May and 21 June 2006, he may have retained useful vision". Instead, Mr A is now legally blind.

Opinion: Breach — Southland District Health Board

Vicarious liability
During the period under investigation, Dr B was employed by SDHB. Under section 72 of the Health and Disability Act 1994 ("the Act") an employer is liable for acts or omissions by an employee unless the employer proves that it took such steps as were reasonably practicable to prevent the employee from breaching the Code.

Dr B breached Right 4(1) and Right 4(2) of the Code, by failing to undertake, and document, important clinical observations. In his explanation for this failure, Dr B pointed to his work environment at Southland Hospital and his acute medical condition. SDHB received a number of complaints from Dr B in relation to the Eye Clinic and administrative staff (but was not made aware of Dr B's physical limitation). In response to my provisional opinion, SDHB provided evidence of the steps taken in response to the concerns raised by Dr B. I note that, in a letter sent to the SDHB CEO

on 14 December 2004, Dr B noted that there had been "some practical resolution" and his request for further change related to the lighting in the consultation room.

It appears that SDHB faced a difficult and protracted situation in trying to resolve Dr B's various complaints. Based on all the available information, I am satisfied that SDHB took reasonable steps to ensure Dr B was able to provide care of an appropriate standard, and is therefore not vicariously liable for his breaches of the Code.

Direct liability

On two occasions Mr A had problems with his bookings at Southland Hospital Eye Clinic.

After seeing Mr A on 27 July 2005, Dr B ordered a follow-up appointment for two weeks, and Mr A was booked an appointment at the Eye Clinic on 17 August 2005. There is no evidence that Mr and Mrs A received notification of this appointment. Although SDHB has advised that Mr or Mrs A cancelled the appointment on 16 August, Mrs A stated that neither she nor her husband received notice of the August appointment, and that neither of them had ever cancelled an appointment with the Eye Clinic. It is possible that the Eye Clinic secretary made an incorrect selection from the drop-down menu and inadvertently cancelled Mr A's appointment. There is no record of any follow-up by SDHB staff after the appointment on 17 August was cancelled and another appointment was not arranged. In its response to my provisional opinion, SDHB advised that follow-up did not occur because "it was quite likely assumed that the patient had cancelled the appointment and would be referred back to the service in the usual manner through his GP".

Mr A next presented on 10 May 2006 with glaucoma, elevated intraocular pressures and cupped optic discs. After his appointment on 10 May, Dr B ordered a follow-up appointment for one week and Mr A was booked into an Eye Clinic on 17 May. However, this clinic was cancelled. Mr A was notified by letter of the cancellation, and told that he would be sent "a letter with a new appointment date and time". An appointment was rescheduled for 24 May, but it too was cancelled after clinic staff twice unsuccessfully attempted to contact Mr A by telephone. No further letter was sent to Mr A and no further attempt was made to re-book an appointment for him.

Mr A did not return to the ophthalmology department until 21 June, after his wife telephoned the hospital on 19 June, seeking an urgent appointment because Mr A had lost his eyesight. Dr Polkinghorne advised:

> "I believe the delay in securing a follow up appointment at the time ordered by [Dr B] was instrumental in leading to [Mr A's] unfortunate outcome. Indeed had [Mr A] been seen ... he may have retained useful vision."

Despite Dr B requesting that Mr A be booked follow-up appointments, this did not occur on two occasions when original appointments were cancelled but not

rescheduled. I note that Dr B had raised concerns in December 2004 about administrative procedures in the ophthalmology department resulting in overbooked clinics, missed bookings and poor follow-up of patients.

SDHB had a duty to ensure that effective systems and processes were in place to adequately manage patient appointments. I note that in another recent case involving SDHB's ophthalmology services, poor record-keeping was evident in that a cataract surgery patient was not recorded within the clinic's records (case 05HDC12122, 29 June 2007). I also noted similar problems in SDHB's urology department from 2002 to 2004 (04HDC13909, 4 April 2006). In that case, I commented: "If a patient's service providers do not work together to ensure that patients waiting for assessment and treatment are adequately informed and managed, it is inevitable that some patients will fall through the cracks, compromising their patient's care."

SDHB had a responsibility to ensure that ophthalmology department patients received appointments, as directed by their clinician, in a timely manner. Where that appointment was cancelled for any reason, it should have been re-booked (in consultation with the relevant clinician if necessary). There should have been a system in place to ensure that ophthalmology department staff were aware of the urgency with which a patient needed to be seen, so that any rescheduling could be done to accommodate more urgent cases as a priority.

In ensuring the smooth running of a specialist department, a district health board is dependent on the co-operation of its specialist staff. If there are only one or two specialists, co-operation is all the more important. Persistent demands from an individual specialist can frustrate the efficient operation of a department. The fact remains that SHDB failed in its duty to appropriately manage patient bookings and provide Mr A with necessary follow-up appointments. In these circumstances, SDHB breached Right 4(5) of the Code.

Recommendations

Dr B
I recommend that Dr B review his practice in light of this report and apologise to Mr and Mrs A for his breaches of the Code, with a copy of his apology to be sent to HDC for forwarding to Mr and Mrs A.

Southland DHB
I recommend that Southland DHB apologise to Mr and Mrs A for its breaches of the Code, with a copy of its apology to be sent to HDC for forwarding to Mr and Mrs A.

I also recommend that Southland DHB arrange an independent audit of its ophthalmology services, including:

- the standard of ophthalmology services
- the standard of documentation
- staff relations
- administrative procedures including the systems for booking, re-booking and following up patients.

Southland DHB should advise the Director-General of Health and the Health and Disability Commissioner of the findings of the audit by **31 October 2008**.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.

- A copy of this report (identifying only Southland DHB and Southland Hospital) will be sent to the Director-General of Health, the Royal Australian and New Zealand College of Ophthalmologists, and the Association of Salaried Medical Specialists, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A

Expert advice obtained from Dr Philip Polkinghorne on 8 June 2007:

" ... I have reviewed the clinical notes taken by [Dr B] and note that [Mr A] was first seen by [Dr B] on the 24th November, 2004. At that visit [Dr B] took an ophthalmic, social and general medical history. [Dr B] made a diagnosis of iritis and instituted treatment with Maxidex and Cyclogel drops.

[Dr B] arranged to see [Mr A] one week later. [Dr B] communicated his findings in a letter to [Mr A's] family doctor ([Dr D]). The letter was typed the day after [Mr A] was first seen. Supporting the diagnoses are clinical photographs which demonstrate signs of acute iritis.

There was no record of the intraocular pressure in the notes at that first visit. [Mr A's] second appointment, scheduled for early December, was subsequently cancelled because [Dr B] was sick. [Mr A] was notified of the cancellation and given instructions to go to the Accident & Emergency Department should there be any problems. A further appointment was made for [Mr A] on 8 December, 2004. At that visit [Mr A's] vision had improved. The treatment was modified at this visit and a further appointment was made for the following week. At the appointment on 22 December, 2004 there was evidence of clinical improvement. [Mr A] was also reviewed on 20 January, 2005, when he had been off drops for two to three weeks.

There is no documentation of [Mr A] having had his intraocular pressures measured at these appointments.

In a handwritten note from a clinical support person to [Dr B] dated 29 June, 2005 it was noted that [Mr A] had 'a flare-up' prompting a further review of [Mr A] on the 13 July, 2005. At this visit there was evidence of a mild recurrence of his iritis and treatment was initiated. [Mr A] was again seen on 27 July, his treatment altered and the notes suggest the recurrence was not severe.

I note in a letter to the family practitioner, [Dr D] written on [27] July 2005 that [Mr A] was to be reviewed in early August 2005. This appointment did not eventuate.

It was not until 10 May 2006, that [Dr B] saw [Mr A] again and at this visit [Dr B] noted [Mr A] had raised intraocular pressures which were recorded at 44 mmHg right and left. [Mr A] was started on Xalatan and Timolol. No record appears in the notes regarding the appearance of the optic nerve heads. Instead the appearance was recorded in a letter written to [Dr D] dated 10 May 2006 and the diagnosis of

glaucoma was recorded. [Dr B] arranged to see [Mr A] the following week but that clinic was cancelled (24 May 2006).[19] [Mr A] was not seen again until 21 June 2006.

[Mr A] was not seen again by [Dr B] and the next entry in the clinical notes at Invercargill Hospital was that of [Dr C]. There is no date recorded at this entry but [it] was most likely made on the 21 June 2006 as this was the date recorded in a letter to Dr D by Dr C and precedes the entry made by [Dr C] on the 23 June 2006. No vision is recorded at the initial entry made by [Dr C], although the letter of the 24 June notes [Mr A's] vision was 6/12 for both the right and the left eye. [Dr C] noted the intraocular pressure was elevated with pressures recorded at 50 mmHg and the optic nerve heads were cupped at 0.9. Additional findings included flare in the anterior chambers, the odd inflammatory cell but no synechiae. Automated visual fields performed on the 21 June 2006 showed marked constriction consistent with advanced glaucoma. [Dr C] formed the opinion [Mr A] had advanced glaucoma, commenced medical treatment to lower his intraocular pressure, arranged glaucoma drainage surgery for 2 days hence and ordered a number of investigations and arranged for a physician to review [Mr A]. This report was not in the file I received but there is a report of a chest X-ray that raised the possibility of either TB or Sarcoidosis.

The subsequent ophthalmic notes indicate the post operative course of [Mr A's] right eye surgery was complicated by hypotony (low intraocular pressure) and a hyphema (blood in the anterior chamber). The latter prompted [Dr C] to consult with a haematologist enquiring as to whether there was a clotting defect. In any event the risk of the proposed surgery on the left eye was judged to be lesser than the risk of the elevated pressure affecting the left eye. Surgery on the left eye was performed on 28 June 2006 and was uneventful.

Following the surgery on the left eye the intraocular pressure was recorded as abnormally low. The vision also was reduced in both eyes at the post operative visit of 30 June 2006. Choroidal effusions were also noted in both eyes. The hyphema in the right eye was thought to be the cause of the reduction in vision in this eye.

The next entry in the ophthalmic notes dated 18 July 2006 was made by [Dr E] who noted that [Mr A] had been admitted to [another DHB] and found to have a lymphoma and had been commenced on chemotherapy. [Dr E] noted [Mr A's] vision had improved to 6/12 right and left, that the intraocular pressures were in the normal range at 14 and 15 respectively and there was no active uveitis in either eye. [Dr E] arranged follow up 2 weeks later and that appointment and the subsequent one on the 18 Aug 2006 revealed satisfactory control of [Mr A's] intraocular pressures. Repeat visual fields did not show any deterioration from his pre-operative status.

[Mr A] meanwhile had been registered with the Foundation of the Blind.

[19] In fact, no appointment was made for Mr A for 24 May 2006.

A letter dated 21 Aug 2006 from [Dr F] noted [Mr A's] most recent ophthalmic findings and a subsequent letter from [Dr E] dated 17 Oct 2006 confirmed these findings.

In summary the ophthalmic notes record the findings of acute but relapsing iritis in [Mr A's] eyes from Nov 2004 to July 2005. [Mr A] was not seen again at Invercargill Hospital until May 2006. At that stage he was diagnosed with glaucoma, and started on anti-glaucoma medications. [Mr A] was not seen again at Invercargill Hospital until 21 June 2006. At that visit [Mr A's] intraocular pressure had increased in spite of the treatment previously prescribed and he underwent bilateral glaucoma drainage surgery. This surgery achieved good intraocular pressure control but his visual fields remained constricted.

In June 2006 [Mr A] was diagnosed with systemic lymphoma and commenced on chemotherapy for this.

The issues raised by the Commissioner include.

1. Standard of Care

In my opinion the standard of care provided by [Dr B] in terms of establishing a diagnosis, initiating treatment, communication with [Mr A's] family doctor was adequate. As to the appropriateness of the timely measurement and recordings of the intraocular pressure recordings, I will deal with this separately.

In my opinion there was an inadequate standard of care given to [Mr A] with respect to receiving timely and appropriate appointments. I believe it was reasonable for [Dr B] to assume that his instructions for [Mr A] follow up visits would be acted on. I suspect the responsibility for making appointments would have likely been delegated to the clerical staff within the eye department. Ultimately I believe it is the responsibility of Southland District Health Board to ensure systems are in place to manage clinic cancellations and patient who 'did not attend'.

2. Should a systemic investigation have been initiated when [Mr A] presented with iritis?

In 2006, a Canadian National Uveitis Survey was initiated sampling 498 ophthalmologists enquiring as to what investigations they would order when presented with 5 scenarios for anterior uveitis. The presence of mutton fat keratic precipitates described by [Dr B] would suggest [Mr A] was likely to have a granulomatous uveitis and in the Canadian survey 70% of respondents would have investigated a patient presenting with the first episode of a granulomatous anterior uveitis. For recurrent episodes the investigation rate was quoted at 83%.

The investigations most often initiated in this survey were chest X-ray, syphilis serology, blood count and biochemistry. It would be very unlikely in my opinion that

any of these investigations would have yielded any useful diagnostic information relevant for [Mr A].

Professor McCluskey, based in Sydney Australia, is a world renowned expert on uveitis and published a paper in the British Medical Journal in 2000 and advocated the 'only investigations that should be performed on all patients with chronic uveitis are a chest X-ray, angiotensin converting enzyme, and syphilis serology'. Professor McCluskey went on to say the rationale for performing these investigations was that they 'may substantially affect long term management'.

In my opinion the most common investigations performed for a patient presenting with uveitis and particularly those signs demonstrated by [Mr A] whilst under [Dr B's] care, would have not influenced the management or outcome. Investigations do have an intrinsic appeal but non-selective approach to testing is costly and inefficient and can produce false positive results. According to Bayes' theorem, diagnostic tests are most helpful when the pre-test likelihood of the disease is about 50%. (Uveitis: Fundamentals and Clinical Practice. 3rd ed.2003 Nussenblatt R, Whitcup S.)

3. Measurement of [Mr A's] intraocular pressure

In [Dr B's] evidence he maintains that he measured [Mr A's] intra ocular pressure but did not record it in the notes. [Dr B] further states the absence of recording [Mr A's] intraocular pressure indicates 'that it must have been normal'.

Raised intraocular pressure is an indicator of glaucoma and as events subsequently proved, [Mr A] was diagnosed with advanced glaucoma by [Dr B] in May 2006. This was treated medically and in my opinion [Dr B] acted in good faith by arranging to see [Mr A] at his next clinic. This appointment as already noted did not occur.

In the 4th edition of 'The Wills Eye Manual' a reputed office and emergency room manual for the diagnosis and treatment of eye disease, published in 2004 the authors examined the risk of raised intraocular pressure in patients with anterior uveitis. They note under other signs (p290) 'Low intraocular pressure (IOP; more commonly seen). Elevated IOP (especially herpetic, lens induced, FHIC, Posner-Schlossman syndrome) …' These authors maintain that low or normal intraocular pressure is more common than elevated intraocular pressure in patients with acute iritis. It is plausible therefore, according to these authors that [Mr A's] intraocular pressure was low or normal as stated by [Dr B] in his evidence.

The pertinent point on [Mr A's] intraocular pressure was that it was not recorded in the clinical notes and in my opinion this was and remains an error of judgement. That not all negative signs are notated during a clinical examination is valid but the absence of any notation regarding the intraocular pressure until 2006 is unacceptable.

4. Examination of the Optic Discs and Retina

In my opinion the examination of the retina and optic nerve heads should have been undertaken at the second visit when the pupils were dilated and the iritis less active. I believe a further examination of the optic discs could have been delayed until May 2006 when the intraocular pressure was noted to be elevated. In fact although not recorded in the clinical notes the findings of cupped discs was included in the letter to [Dr D] dated 10 May 2006.

In [Dr B's] brief he does not address the issue of the examination of the retina and optic nerve head appearance, but nor was he asked for an explanation. I can only comment what would be ideal, and that would be to include an examination of the retina and optic nerve head appearance and record the findings in the clinical notes.

5. Appropriate Investigations in presence of elevated intraocular pressure

In my opinion in the presence of raised intraocular pressure it would be appropriate to assess the angle, an anatomical part of the eye concerned with drainage of the intraocular fluid. This can be assessed directly through a gonio lens or indirectly by the depth of the anterior chamber. The latter test is less reliable. The second investigation would be to assess the visual fields. However I agree with [Dr B]; the management of grossly elevated intraocular pressure is more relevant than arranging investigations in the first instance. Assuming [Dr B] had excluded closed angle glaucoma as the cause of raised intraocular pressure the investigations could have been reasonably deferred until the week following.

6. Primary Intraocular Lymphoma

Primary intraocular lymphoma is a rare condition and represents a form of non-Hodgkin's lymphoma. This disease primarily involves the retina and vitreous and typically presents with decrease in vision and floaters. Primary involvement of the anterior uvea (anterior uveitis and iritis) is very rare. (Coupland SE, Foss HD et al. Ophthalmology 1999; 106: 2109–2120) One such case was reported in 2002 in Archives of Ophthalmology in a 31 year old patient presented with anterior uveitis whose signs included white keratic precipitates (not mutton fat) and a hypopyon (pus in the anterior chamber). These signs do not fit with [Mr A] and furthermore most cases presenting with ocular lymphoma have systemic involvement at the time the eye condition is diagnosed. In other words most cases where lymphoma involves the eye the primary is at a distal site. (Peterson K, Gordon KB et al Cancer 1993 843–9)

In my opinion there is no evidence to suggest [Mr A] had an intraocular lymphoma when under the care of [Dr B] or when [Mr A's] care was transferred to either [Dr E], [Dr F] or [Dr C].

7. Steroid Use

I believe the use of topical steroids for the treatment of [Mr A's] iritis was entirely appropriate. Topical steroids are the mainstay of treatment for most forms of anterior uveitis. If [Mr A] had a documented increase in intraocular pressure then steroids will still likely have been prescribed. The difference in treatment would have, I believe, been related to managing this complication. If [Dr B] had recorded the intraocular pressure in [Mr A's] notes this issue could be more easily settled.

8. Other aspects of care

I believe as stated [Dr B] erred in not recording [Mr A's] intraocular pressure in the clinical notes. This would be evidential in supporting [Dr B's] allegation that [Mr A's] intraocular pressures were normal up until May 2006. In any event I believe the delay in securing a follow up appointment at the time ordered by [Dr B] was instrumental in leading to [Mr A's] unfortunate outcome. Indeed, had [Mr A] been seen between the 10 May 2006 and 21 June 2006 he may have retained useful vision.

In [Dr B's] brief he reports dissatisfaction with the arrangements at the eye clinic particularly with respect to the design and support. Some of these issues may have been made worse by his own ill health. It appears that the subsequent break down in the relationship between [Dr B] and Southland District Health Board was inevitable and in retrospect may have been better managed by both parties.

This however does not help [Mr A] and I suspect the information received by [Mr A] after his care was transferred from [Dr B] was not always supportive. Denying that support may have limited the chance of [Mr A] to be successfully rehabilitated. I have no doubt some of the information given to [Mr A] was given in good faith such as suggesting the underlying diagnosis of the intraocular inflammation may have been the result of intraocular lymphoma. However some of the information conveyed to [Mr A] appears to be inflammatory and was not helpful and is not supported by the documents I have reviewed."

Further expert advice*:*
In subsequent correspondence, Dr Polkinghorne provided the following advice:

- [Dr B] should have examined [Mr A's] retina and optic nerve heads as a matter of course when he first presented with iritis to ensure that the cause of the iritis was not from the back of the eyes, and also to check that [Mr A's] optic nerve heads were of equal size.

- If [Dr B] had failed to examine [Mr A's] retina or optic nerve heads when he first presented with bilateral iritis in late 2004, this would be viewed with moderate to severe disapproval by his peers.

- Intraocular pressures of between 15–20mmHg are perfect, but no action would generally be taken unless measurements were below 10 or above 25. Intraocular pressures that were over 20 or below 15 would be an alert to a possible problem, so monitoring for change should occur.

- "Measurement of intraocular pressure is a normal part of most ophthalmic examinations", and should have been checked "at every visit or at least every second visit".

- It was reasonable for [Dr B] to exclude closed-angle glaucoma on 10 May 2006 because [Mr A] did not present with symptoms indicative of the condition and was "in the wrong age-group and would be unlikely to have dual pathology".

Appendix B

Further expert advice obtained from Dr Polkinghorne on 5 March 2008

Further expert advice was obtained in view of [Dr B's] response to my provisional opinion (dated 5 March 2008):

> "Thank you for your letter dated 18 February, 2008 requesting a response on items that the Commissioner has notated.
>
> 1. The nature of the procedure used to measure the intraocular pressure and whether a patient would find the procedure uncomfortable.
>
> A. There are a number of ways to measure intraocular pressure, but in clinical practice, the vast majority of ophthalmologists would use a Goldmann tonometer. This involves placing a local anaesthetic drop into the eye, which may cause transient stinging for a few seconds. The tonometer, which may be attached to a standard slit lamp microscope or placed on the microscope, is then placed against the now anaesthetised cornea and a measurement of intraocular pressure can be recorded. This procedure in a compliant patient may only take a few seconds and most patients would not find the procedure uncomfortable. Indeed, they may not be aware that this is a separate procedure from the examination of the eye.
>
> 2. Whether examination of a patient's retina and optic nerve heads is a routine matter that would always be carried out on a patient presenting with uveitis.
>
> A. In my opinion, the examination of a patient's retina and optic nerve heads would be a routine matter for a patient presenting with uveitis. This part of the ophthalmic examination, in my opinion, is a requirement to ensure that there is no inflammation in the posterior segment which would require different management. Having said that, it is not always possible to carry out such an examination. For example, patients with small pupils, adherent pupil cataract and other intraocular pathologies may prevent this examination from being performed.
>
> 3. Whether [Mr A] had 'chronic' or 'acute' uveitis.
>
> A. These are clinical descriptions at either end of a spectrum. Acute uveitis is typically used for a patient presenting with a recent history of uveitis which responds quickly to treatment and then goes into remission. Chronic uveitis is where the condition persists for a prolonged period, which would, I believe, be typically measured in months. In my opinion, [Mr A] most likely had acute uveitis, although there are obvious periods of relapse. I do not believe I have sufficient evidence to suggest that [Mr A's] uveitis was chronic.

4. The appropriateness of not documenting examinations that revealed normal findings (see [Dr B's] comment, p.42).

A. I have already commented in my original report that not all negative signs are notated during a clinical examination. I further comment that the absence of any notation regarding intraocular pressure until 2006 was unacceptable. I believe that there would be a requirement in a clinical scenario described by [Dr B] and relayed by [Mr A's] evidence that the intraocular pressure should have been recorded in the notes. [Dr B] maintains that he did measure [Mr A's] intraocular pressure, examined the retina and optic nerve heads, but failure to document these findings was, in my view, at least an error of omission.

5. When [Mr A's] intraocular pressure should have been measured, based on his presentation.

A. I believe it would have been appropriate to measure [Mr A's] intraocular pressure at presentation.

6. [Dr B's] comment that your advice was based on 'the situation in a very well-staff Auckland Public Hospital' (see p.41).

A. I do not believe my advice has been adversely impacted by my work experience at Auckland Public Hospital. Indeed, I have worked in Southland Eye Clinic, Wellington Hospital Eye Department, Whangarei Base Hospital and Counties Manukau Superclinic.

7. Whether it would have been good practice for [Dr B] to conduct further investigations into the cause of [Mr A's] uveitis (notwithstanding that, with hindsight, such investigations would not have revealed lymphoma).

A. I believe I have already addressed this in my original brief. In think the laboratory investigations would not be good practice unless there were symptoms or signs picked up during the examination and/or the uveitis was chronic or atypical."