Eye Department's management of urgent cases (00HDC09046, 25 October 2002)

Public hospital ~ Eye Department ~ Ophthalmologist ~ Patient monitoring and response to cancer ~ Delays ~ Resource constraints ~ Rights 4(1), 4(5), 6(1)(a), 6(1)(b)

A 78-year-old man complained that ophthalmologists at a public hospital did not advise earlier that tissue spreading over his left eye was cancer, and did not offer the option of transferring tissue from his right eye. He also complained that after surgery, which kept his eye free of cancer for two years, the subsequent management was not effective and he was not monitored effectively, creating the need for removal of his left eye.

The complaint was also that: the Eye Department did not respond adequately to the urgency and delayed an urgent appointment; insufficient reading of the case notes prevented the treatment of his eye; there was poor communication between clinicians because of inadequate clinical notes (as evidenced by his being asked about the rate of the spread of cancer instead of this being documented in the notes); and there was insufficient information between the clinicians and administration (as shown by the delays in obtaining an urgent appointment).

The Commissioner held that there was adequate monitoring and follow-up, as the reviews were regular, timely and ongoing, and there was no evidence that the management contributed to the loss of the patient's eye. It was likely that the ophthalmologists read the case notes and were alert for signs of recurring carcinoma; significantly, there was no evidence that the carcinoma should have been diagnosed earlier.

The clinical entries made by ophthalmology staff in the outpatient setting appropriately recorded the chronic and progressive nature of the condition, although the standard of detailed corneal drawings would ideally have been higher.

There was no breach of Right 6(1)(a) because, although the patient was not fully aware of the potential for recurrence, the consequences were explained to him as soon as it became apparent that the lesion had progressed to a squamous cell carcinoma. Although the patient maintained that he was never offered the option of restoring his left eye, there was no breach of Right 6(1)(b) because the records showed that the option of a stem cell autograft was discussed and offered on a number of occasions.

It was noted that while every patient with this condition should be treated soon after diagnosis, restraints on staff and resources make this an impossible goal. However, the Eye Department should ensure that, in scheduling appointments, "urgent" cases are prioritised, patients' requests for earlier appointments are dealt with appropriately, and patients are kept well informed. There was a breach of Right 4(5) by the department because it did not provide the patient with the recommended urgent appointment.