Ophthalmologist, Dr B

A Report by the

Health and Disability Commissioner

(Case 03HDC13528)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer
Dr B	Provider, Ophthalmologist
Dr C	Ophthalmologist
Ms D	Optometrist

Complaint

On 10 September 2003 the Commissioner received a complaint from Mrs A about the services she received from an ophthalmologist, Dr B. The following issues were identified for investigation:

- the appropriateness of Dr B's ophthalmological assessment of Mrs A in July 2002
- the accuracy of the information Dr B gave to Mrs A about the treatment options relating to her eye surgery.

An investigation was commenced on 26 November 2003.

Information reviewed

1. Information from Mrs A
2. Letter supporting Mrs A's complaint and accompanying documentation from Dr C
3. Information from Dr B
4. Information from Dr C

Independent expert advice was obtained from Dr Ralph Higgins, ophthalmologist.

Information gathered during investigation

On 15 July 2002 Mrs A (aged 85 years) was referred to ophthalmologist Dr B by her optometrist, Ms D, who had noted that Mrs A had bilateral cataracts. Mrs A said that Dr B informed her that she had cataracts on both eyes and had damage to her right eye. Dr B recalled that he found "some blood vessels over the right optic disc" suggesting previous vascular occlusion and suggested that a left cataract removal might best improve her vision.

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

Dr B said that Mrs A could not recall any incident that might have led to poor vision in her right eye.

Dr B measured Mrs A's vision at right 6/18 and left 6/24+ refracted.

Dr B said that he advised Mrs A that while her cataracts did not "need" to be removed, removal would improve her vision and that she should consider removal of the cataract on the eye she considered to be the worst. Dr B's assessment of Mrs A's clinical priority assessment was 23-26 points using the national clinical priority assessment criteria (CPAC) for cataract surgery.

The CPAC has five domains: visual acuity score; clinical modifiers; severity of visual impairment; ability to work, give care, live independently; and other disability. According to Dr B's assessment, Mrs A did not drive and was functioning reasonably in her own home, which was close to amenities, her GP and friends.

Dr B said that he advised Mrs A that while having the operation at the public hospital would not incur any cost to her, the waiting list at that time for people with a similar CPAC score was two years at worst.

Mrs A confirmed that Dr B told her the wait for surgery at the public hospital might be up to two years. She said Dr B told her that if she could pay, he could do the surgery privately the following week, at a cost of $6000. Mrs A said she told Dr B she did not have the money but that she would try to raise enough money to have one eye done. Dr B stated that cataract removal performed in a private hospital would be approximately $3000 per eye. Dr B said Mrs A did not ask to go on the waiting list at the public hospital and, as he did not hear from her, he assumed she had had her cataract removed privately by another surgeon. Dr B said that he "directly suggested and offered" Mrs A the possibility of going on the waiting list at the public hospital; however, Mrs A maintained that Dr B did not explain that it was possible to have the operation done in the public system.

Mrs A was not able to raise the money initially but one year later a friend offered to lend her the money.

In July 2003 Mrs A saw Dr B again to arrange to have the cataract operation. Dr B arranged for Mrs A's admission to the private hospital. Mrs A said that Dr B asked at this appointment, and again when he telephoned her to make arrangements for the operation, which eye she felt was worse. Dr B said that he needed to confirm Mrs A's view of which eye was worse as both eyes would benefit from cataract extraction and patients often have a dominant eye they prefer to have restored to full vision first.

Mrs A decided not to go ahead with Dr B's arrangements. She asked Ms D to arrange a second opinion for her and on 14 August 2003 she saw another ophthalmologist, Dr C. Dr C advised Mrs A that she did not have damage to the right eye but had cataracts on both eyes, for which surgery could be arranged at the public hospital in six months' time. Dr C

further advised Mrs A that Dr B's assessment of the waiting list time was wrong. In a letter to Ms D dated 20 August 2003 Dr C advised that his assessment of Mrs A's clinical priority was 45 points, which meant she would receive surgery in the public system within a few months at most (see Appendix 1). Dr C arranged for Mrs A to go on the waiting list for a right eye cataract operation.

Mrs A complained that Dr B had not given her accurate advice about the waiting list, and that she had been "grossly misled". Dr C wrote in support of Mrs A's complaint. Dr C said that when he saw Mrs A in August 2003 he found her vision to be "identical" to the recording of her optometrist in July 2002, ie, right 6/18 (part), left 6/24 (part) with marked cataract change. Dr C advised Mrs A that her degree of visual loss qualified her for prompt cataract surgery via the public system. Dr C stated that there was no way that Mrs A should have had to wait two years or more in the public system when she was seen by Dr B in July 2002.

In his response to Mrs A's complaint, Dr B stated:

> "[Mrs A] has found this whole process very upsetting … and I am very sorry this has occurred. I note that my consultation with [Mrs A] occurred during my 3rd week of private practice. I soon became more used to the private system, and changed some of my ways of doing things, to provide less room for misunderstanding and to provide better service to patients. I now copy all my letters to the patient's GPs or optometrists to the patients to ensure that they are fully aware of what is being planned and what options have been offered to them. I also include in the reporting letter a standard statement explaining the way in which the waiting list works."

Dr B informed me that as of 30 June 2003 there were 87 patients on the public hospital cataract waiting list with 26 or fewer points who had waited two or more years. Dr B stated that Dr C's CPAC assessment was inaccurate in the following respects:

> "Section 1: Visual acuity score
> [Mrs A's] vision is recorded as 6/18, 6/24 in [Dr C's] clinical record resulting in 15 points, yet the waiting list form records 22 points (equalling 6/24, 6/36).
>
> An additional 5 (maximum) points was given for loss of near vision (N12). No near vision is recorded in the clinical record and the near vision (N12) does not correspond as it should to the distance vision.
>
> Section 2: Clinical modifiers
> It is clearly stated on the form: 'If best corrected visual acuity (BCVA) better than 6/24 in eye to be operated on, add 5 points only if posterior sub-capsular cataract present – to offset good visual acuity (VA)'.
>
> [Mrs A's] visual acuity recorded on [Dr C's] clinical record (6/24) and on her waiting list form (6/36) is not 'better than 6/24' and her cataract is documented as nuclear

sclerosis only, on [Dr C's] clinical record (++NS++), which I confirmed at my assessment. Yet [Dr C] has added 5 points.

Section 3: Severity of visual impairment, Gross visual function
[Mrs A] has been given 4 points 'nearly impossible' and yet she is functioning well in her own home, lives in the centre of [town] close to shops and her GP, and has a wide group of supportive friends.

I would have given 2-3 points 'difficult' at most.

Section 4: Ability to work, give care, live independently
4 points were given (between 'difficult' and 'impossible') and yet [Mrs A] does not work or care for anyone and has been managing well in her own home with support from her GP and friends. I would have given 2-3 points 'difficult'.

Section 5: Other disability
[Mrs A] was given 5 points 'severe disability' and yet her pre-operative assessment (attached as '7') before surgery 31.10.03 found the only active medical problem to be raised blood pressure (210/80) for which she was referred back to her GP with routine priority. (See 'pre-operative assessment for eye surgery') and she was 'fit for LA' = local anaesthetic, (attached and marked '7'). I would have given 2-3 points 'moderate disability'."

Dr C has provided me with information setting out the basis of his CPAC assessment and confirms that he considers it to be accurate and that, if anything, Mrs A should have been given more points.

Independent advice to Commissioner

Initial advice
The following expert advice was obtained from Dr Ralph Higgins, an independent ophthalmologist:

"RE: COMPLAINT – [MRS A]
Your Reference: 03/13528.

There is no personal professional conflict in this case.

I have read the documents that have been presented to me:-

1. Letter of complaint from [Mrs.A], undated (pgs 1-2).

2. Letter supporting [Mrs A's] complaint and accompanying documentation of [Dr C], dated 2 September, 2003 (pgs 3-9).
3. Action note of telephone conversation between investigator and [Mrs A] dated 27 November, 2003 (pg 10).
4. Letter of response from [Dr B] and accompanying documentation, dated 5 February 2004 (pgs 11-46).
5. Action note of telephone conversation between investigator and [Dr B], dated 2 March 2004 (pg 47).

You have asked:-

1. Please explain the relevance of [Dr B's] finding of 'some blood vessels in the right optic disc' during the examination of [Mrs A's] eyes.

Dr B's noted some fine blood vessels in the right optic disc and thought these may have been collateral vessels from retinal vascular occlusion which is a reasonable assumption.

2. Please interpret [Dr C's] clinical assessment (p39) and explain his finding in terms of visual acuity score, clinical modifiers, severity of visual impairment and gross visual function.

Having examined the record noted as National Clinic Priority Assessment Criteria (CPAC) for Cataract Surgery (pg.8 dated 14 August, 2003) for [Mrs A] – Referring Consultant [Dr C].

I note that this document is repeated on Page No. 40 as well.

I note that there are a number of entries in the records that suggest that the vision of the right eye was 6/18 and the left eye was 6/24. This would give a visual acuity score of 15 and not 22.

I note that there is no record of the near reading acuity from the records provided. The type of cataract is recorded on a number of occasions as having been nuclear cataracts and not posterior sub capsular cataracts then the near reading acuity should be no worse than N6.

In regard to **Section 2, clinical modifiers** I note that 5 was added for a posterior sub capsular cataract but there is no posterior sub capsular cataract present. This should have given a reading of zero to one.

In regard to **Section 3: Severity of visual impairment,** where it says

(A) Gross visual function: any difficulty with glasses, recognising faces, watching TV, cooking, playing sports/cards etc.

From reading the records I would have thought that this would have been a severity of visual impairment of 2 or at the worst 3.

With regard to Driving Mobility I agree that this should be 0 as the patient does not drive.

Section 4. Ability to work, give care, live independently.

From the records and history that I can read I would have thought that this would be probably a 2 to 3.

In regard to **Section 5: Other Disabilities.**

She had no significant other disabilities from perusing the records, she would probably have scored a 1 to 2.

This would give a total score at a maximum of 15 + 1 + 2 or 3 + 2 or 3 + 1 or 2 would give a total score of between 21 and 24.

4. Please interpret the ophthalmologic assessment [Dr B's] carried out on [Mrs A] in July 2002.

From [Dr B's] records the corrected vision is recorded as 6/18 right eye 6/24 left eye.

He records that she had bilateral nuclear sclerosis, intra ocular pressure was normal. He noted some fine vessels on the right optic disc which he thought may be normal or may be collateral and that she denied any past history of loss of vision of the right eye. He recommended that she would benefit from cataract surgery and recommended a left phacoemulsification and insertion of posterior chamber intraocular lens. He offered public and private in his notes. He discussed the cost and the wait suggesting the wait would be between 12 and 18 months and at most 24 months. He recorded that she wants to go privately and that she would contact him when she wished to go ahead.

5. Was [Dr B's] assessment in 2002 consistent with his finding of 23-26 CPAC and the consequent waiting list times at the public hospital?

I do agree with [Dr B's] assessment that it is consistent with his findings of 23-26 CPAC and that the waiting list times as noted in the records.

6. Can you please comment on [Dr B's] questioning [Mrs A] on which eye she felt was the worse at the time of her second consultation and a week later by phone.

This is a very important part of any clinical examination to determine which is the worse eye as the worse eye is normally operated on first giving the patient the benefit of the

vision in the better eye should anything happen to the worse eye during surgery or delay in healing of the worse eye following surgery.

7. (a) What treatment options were appropriate?

Treatment options were that she should be listed for a left cataract extraction with insertion of posterior chamber intra ocular lens on the Public Waiting List and that she should have been put on the waiting list at the time that [Dr B] first saw her.

(b) Was the information provided about treatment options appropriate/ accurate?

The information provided about treatment options was appropriate and accurate.

8. Are there any additional comments you would like to make?

It would appear from my reading of the records that [Dr B's] has assessed [Mrs A] correctly in his estimate according to the National Clinic Priority Assessment Criteria CPAC for Cataract Surgery. However I feel that he failed to put [Mrs A] on the waiting list and that is the only criticism that I have of [Dr B].

I am surprised that [Dr C] did not give more care when filling in his National Clinical Priority Assessment Criteria CPAC for Cataract Surgery Form which was dated 14 August, 2003 as he appears to have overstated her visual disability. However this has resulted in a happy outcome for [Mrs A] in that her operation was performed within a reasonable length of time considering the delay involved in putting her on the waiting list from her first consultation with [Dr B's] in July, 2002."

Additional advice
The following further advice was obtained from Dr Higgins in relation to the information provided by Dr C about his CPAC assessment of Mrs A:

"**In answer to your question 1, are [Dr C's] comments concerning the assessment of 'part' and 'minor' correct?**

I am happy to accept that if [Dr C] states that the vision was 6/24 in the right eye and 6/36 in the left eye from having reviewed his records that I will assume that these were correct. He states in his letter that [Mrs A], when he saw her had posterior subcapsular cataract and I will accept that. I will also accept his assurance that the near vision was N12 from the new information he has supplied.

I will also accept that he feels that [Mrs A] does have significant disabilities and the score of 4 may be reasonable for this.

In consideration of the new information, and revised records it would therefore be reasonable to change the CPAC figures to 22 for the vision scoring, + 5 for the N12 that

[Dr C] states was her near vision which would be in keeping with his suggestion that [Mrs A] had posterior subcapsular cataracts. Then score 5 for her clinical modifiers for the posterior subcapsular cataract and 4 for the severity of visual impairment. Then 4 for her ability to work, give care and live independently and a 4 or 5 for her other disabilities from the new information supplied by [Dr C] regarding [Mrs A].

This would give a total score of 44 or a possible 45.

In answer to your question 2, on the basis of the new information supplied then I would be prepared to accept that [Mrs A's] vision score based on [Dr C's] new information would be 22.

Question 3. Is it possible [Mrs A's] vision deteriorated in the 12 months since seeing [Dr B]?

I think that this is quite a likely possibility particularly on reading [Dr B's] report and noting that he described in his record that she had nuclear cataracts and he records her vision as being 6/18 + in the right eye on page 27 of his admission, he has recorded the vision as 6/18 refracted in the right eye and 6/24 + refracted in the left eye and he notes that NS ++ which is nuclear sclerosis being a nuclear cataract and he has ACLO meaning there are some anterior cortical lens opacities as well.

So it would appear in the 12 months time she has gone from nuclear cataracts to posterior subcapsular cataracts from an N value of about N5-N6 to an N value of about N12 and I have no reason to doubt either [Dr C's] description or [Dr B's description.

Question 4. What is your opinion on the assessment performed by the optometrist?

I presume this relates to the test on the 15th July 2002, which has a number 5 on the pages you have previously sent me.

It records the vision as 6/18 minus in the right eye refracted and 6/24 minus in the left eye refracted. I would have taken this to mean that the vision was almost 6/18 in the right eye and almost 6/24 in the left eye and I would be interested to know what the optometrist's opinion of her report was.

In normally assessing the vision as 6/18 minus, one would be suggesting that the vision was almost 6/18 and when one suggests the vision was 6/24, one would normally suggest that this was almost 6/24.

If in fact the vision in the right eye was only slightly better than 6/24, normally it would be written as 6/24+.

If one was considering that the vision in the left eye was only slightly better than 6/36 one would normally write 6/36+ indicating the vision was a little better than 6/36.

Under these circumstances and based on the new information available, then I would suggest that the vision on the 15th July 2002 was 6/18 almost and almost 6/24 in the left eye. As these readings are subjective, and depend upon the illumination of the chart, and the contrast of the letters as well as the size and width of the letters and is also dependant upon how the patient feels on the particular day, whether they were concentrating well or tired, or whether their multiple disabilities were in fact distracting them. It also depends whether or not the person who is measuring the vision pushes the patient to try harder with the vision. It is a very subjective reading depending upon a number of factors and it is often not completely possible to compare one person's finding with another person. I would therefore give the benefit of the doubt to [Dr B] in his vision of 6/18 in the right eye and 6/24 in the left eye when he measured the visions in his office.

Question 5. Was [Dr B's] assessment of [Mrs A's] vision appropriate?

As above I have no reason from the new information supplied to doubt [Dr B's] assessment of [Mrs A's] vision.

Question 6. Do you wish to review your opinion concerning [Dr B's] assessment of [Mrs A]?

No, I do not feel that there is anything in the new information to suggest that I would wish to change my opinion regarding [Dr B's] assessment of [Mrs A].

Question 7. Please add any other comments.

I have no reason not to believe the records that [Dr B] has put forward and I have no reason not to believe the additional information that has been supplied by [Dr C]. I would perhaps suggest that in future when recording visions that the doctors concerned should make it clear that they are in fact recording a lower vision than what they are entering into their notes. It would be much better if they recorded a 6/24 + rather than a 6/18 minus if they mean 6/24 and it would be better if they recorded 6/36 + and not 6/24 minus when they are actually suggesting that the vision was 6/36. It would also be worthwhile for those recording visions to enter the reading correction on their notes at the time when they are recording the distance vision so that one can know whether the reading vision is a reduced vision or a normal reading vision. I would also suggest that if posterior subcapsular cataracts are present that they should be recorded in the patient's clinical records rather than on the operating notes, presuming that the pupils were dilated pre-operatively and the maculae were examined and the lens was examined fully pre-operatively."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

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

RIGHT 5
Right to Effective Communication

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. …

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
   a) An explanation of his or her condition; and
   b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; …

Opinion: No breach – Dr B

Assessment and treatment options
Dr B diagnosed Mrs A with bilateral cataracts in July 2002. He gave her a score of 22-26 points using the national assessment criteria for cataract surgery (CPAC). Based on this score he advised Mrs A that her wait for public hospital admission could be long, maybe up to two years, but that she could have surgery done privately the following week. In July 2003, after a second consultation with Dr B, who booked her for private surgery, Mrs A sought a second opinion from Dr C as she was not confident that Dr B had made an accurate assessment of her eyesight and was apprehensive about paying for private cataract surgery.

In August 2003, Dr C gave Mrs A a CPAC score of 45 points and, on the basis of this score, advised Mrs A that her degree of visual loss qualified her for prompt cataract surgery in the public system.

On the basis of Dr C's advice, Mrs A complained that Dr B had given her incorrect information about the waiting list times based on an inadequate assessment of her condition.

My advisor commented:

> "I do agree with Dr B's assessment, that it is consistent with his findings of 23-26 CPAC and that [of] the waiting list times as noted in the records … It would appear from my reading of the records that Dr B's has assessed Mrs A correctly in his estimate according to the National Clinic Priority Assessment Criteria CPAC for Cataract Surgery …."

I accept my expert advice. In my opinion Dr B accurately assessed Mrs A's priority for cataract surgery and provided her with accurate information on the treatment options and the likely waiting list time. Accordingly, he provided services of an appropriate standard, and appropriate information, and did not breach Right 4(1) or Right 6(1) of the Code.

In relation to the differing CPAC assessments of Dr B and Dr C, I note my expert's advice that it was "quite a likely possibility" that Mrs A's vision deteriorated in the 12 months between seeing Dr B and Dr C .

Other comment

Placement on waiting list
I note my expert's comment that Dr B should have put Mrs A on the waiting list when he saw her in July 2002. Dr B said that Mrs A did not take up his offer to be put on the waiting list while Mrs A states that no explanation was given about this possibility. Mrs A informed me that she told Dr B, at the appointment in July 2002, she would "endeavour to raise enough for one eye". When Mrs A did not return to see him, Dr B assumed that she had had the operation performed privately by another surgeon. I am not persuaded that, under these circumstances, Dr B was obliged to put Mrs A on the waiting list. However, I bring my expert's comment to Dr B's attention.

Effective communication
Mrs A's letter of complaint suggests that she left her consultations with Dr B in July 2002 and July 2003 without a clear understanding of her condition, her options for surgery, and the way in which the waiting list works. She also did not understand why Dr B wanted to know which eye she felt was worse. Mrs A was aged 85 years when Dr B first saw her. I note that in July 2002 Dr B was only in his third week of private practice.

All patients – especially elderly patients waiting for surgery in the public system – need clear information about their condition and treatment options. I commend Dr B on the steps he has taken since these events to provide copies of letters to patients (so they can read for themselves his advice to their GP or optometrist) and a standard statement explaining the

way in which the waiting list works. These steps should help Dr B's patients to understand information he provides at consultations, and are consistent with his legal duty (under Right 5(1) of the Code) to communicate effectively "in a form … that enables the [patient] to understand the information provided".

The information provided by Dr C in relation to his CPAC assessment included details about Mrs A's domestic situation and medical history that were not mentioned by Dr B. These details were relevant to eligibility for surgery. I recommend that Dr B review his practice in completing CPAC assessments and obtain and record as much relevant information as possible from patients.

Recording vision
I draw Dr B's and Dr C's attention to my expert's comments on recording vision measurements in the patient's clinical records.

Follow-up actions

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

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