Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion - Case 98HDC14086

Complaint

The Commissioner received a complaint from the consumer and his wife about services provided to the consumer by the first neurosurgeon, the second neurosurgeon and the neurologist. The complaint is that:

The neurologist

- *The neurologist did not refer the consumer to specialist ophthamology services for investigation of persistent papilloedema.*

The second neurosurgeon

- *The consumer and his wife were not advised they were to see a registrar at an appointment in early February 1998. They understood they were to see the second neurosurgeon.*
- *In early February the second neurosurgeon reluctantly agreed to speak with the consumer and his wife. His manner was arrogant and he walked out on the consumer and his wife before they had asked all their questions.*
- *The consumer and his wife faxed their questions to the second neurosurgeon on the same day. They received no response from the second neurosurgeon.*
- *The second neurosurgeon did not respond to correspondence from the second ophthalmologist, regarding the consumer's deteriorating vision.*

The first neurosurgeon

- *The first neurosurgeon advised the consumer that an operation to relieve benign inter-cranial hypertension was a straight forward operation and the consumer would be back at work after five days. The first neurosurgeon did not fully inform the consumer about the post-operative course of the operation or the likelihood of visual impairment.*
- *The first neurosurgeon did not refer the consumer to specialist ophthalmology services to assess and treat the consumer's deteriorating vision.*

Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Investigation

The Commissioner received the complaint on 20 April 1998 through Health and Disability Advocacy Trust and an investigation was undertaken. Information was received from:

The Consumer
The Consumer's Wife
The First Neurosurgeon
The Second Neurosurgeon
The Neurologist
The General Practitioner
The First Ophthalmologist

The consumer's medical records were obtained from two public hospitals. The Commissioner also sought advice from an independent neurosurgeon.

Information Gathered During Investigation

While in another country in 1996 the consumer suffered headaches on the right side of his head. He saw his general practitioner and was referred to a specialist in the capital city who suggested that the consumer see a neurologist when he returned to New Zealand. In January 1997 on his return to New Zealand the consumer saw his general practitioner in his home town. By July 1997 the consumer's headaches persisted and he also suffered visual problems whereby he would lose his sight for several seconds before returning to normal. He again consulted his GP who examined his eyes and finding the optic disc swollen referred him to an eye specialist. The second ophthalmologist diagnosed bilateral papilloedema and referred him that day to the neurologist.

In mid-July 1997 the neurologist examined the consumer and wrote to the second ophthalmologist. He agreed with the second ophthalmologist's diagnosis and ordered an MRI scan to ascertain the cause of the papilloedema. The MRI scan showed no brain tumor and the neurologist diagnosed benign intra-cranial hypertension.

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

Over the next three months the consumer had eight lumbar punctures to relieve the elevated pressure in his brain and spinal cord. He was also treated with a diuretic and prednisone. After the first three lumbar punctures were ineffective the neurologist referred the consumer to the third ophthalmologist. The third ophthalmologist advised the neurologist in early September 1997 that the consumer's visual acuity was within normal range, but he would continue to monitor the consumer because of the disc swelling. In addition, the consumer was referred to a neurosurgical outpatients clinic at the first public hospital in mid-September 1997. The neurologist advised the Commissioner that:

> *"When* [the consumer], *after having initial lumbar punctures, was transferred to* [the first Crown Health Enterprise ("CHE")] *for further management he saw* [the third ophthalmologist], *Eye Surgeon* [in early] *September 1997. Therefore* [the consumer] *had seen two eye surgeons already by the time he was referred to* [the second city]. *I see one or two patients with benign inter cranial hypertension a year. Only a few of them have required a surgical opinion. Most such cases are initially treated with medical means and if these fail then our standard policy has been to refer them to the neurosurgeons. As a rule, unless there has been a dramatic change in the patient's condition, such referral is made on an out-patient basis and patients seen in the Neurosurgical outpatients which are conducted in* [the first] *hospital.*
>
> *Throughout the past eleven years that I have been in* [the second city], *and also before, this has been the standard practice concerning all patients with this condition."*

There is no evidence that other treatment options were discussed with the consumer and his wife. The consumer attended the outpatient appointment in early October 1997. The first hospital does not have a neurosurgeon so specialists travel from the second hospital to provide outpatient services in the region. The consumer was examined by the second neurosurgeon and a colleague from the second hospital who advised that he would require intracranial pressure monitoring ("ICP") for twenty-four hours followed by the insertion of a lumbar peritoneal shunt to relieve the raised pressure.

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

Five days later the consumer saw another visiting neurosurgeon, the first neurosurgeon, at outpatients at the first hospital. The first neurosurgeon advised the Commissioner that:

> *"The first time I saw him* (the consumer) *he had already been seen by several other physicians, and I basically confirmed the previously planned lumbo peritoneal shunt with him. This was the plan because he had been diagnosed as having benign raised inter-cranial pressure, an ill-defined condition that leads to headaches and can be associated with visual impairment.*
>
> *As far as the information given to him regarding the procedure, I am happy to confirm that a shunt procedure is a relatively minor operation that is often done by junior staff in a neurosurgical department. I personally have performed numerous shunt procedures and have a good understanding both theoretically and practically of the potential complications. I do not recall the "back at work in five days" statement, but this would be an over optimistic expectation of any patient undergoing a neurosurgical operation."*

There is no evidence that other treatment options were discussed with the consumer and his wife. The consumer's subsequent appointment with the third ophthalmologist for mid-October 1997 was cancelled. Five days later the consumer was admitted to the second public hospital for insertion of a shunt. The operation was performed on the following day and the discharge summary recalled:

> *"Essentially a lumbo peritoneal shunt without a valve but with a distal split valve mechanism was inserted in the standard manner without complications."*

POST OPERATIVE COURSE

> *"*[The consumer] *experienced some headaches and dizziness in the first several days following insertion of his shunt particularly in the morning and on moving to a vertical position. He did however begin to tolerate his shunt and was able to be discharged on* [a date in mid-October].

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

> *At the time of discharge he was on prednisone 15mg* […]. *He is o be seen neurosurgically approximately six weeks after discharge and I assume that appointments will be made for* [the consumer] *to see* [the neurologist] *directly in one of his clinics."*

Following discharge the consumer continued to suffer pain and his condition progressively worsened. The consumer's wife tried unsuccessfully to contact the first neurosurgeon and sent a fax to him on two occasions in late October 1997 about the consumer's condition. On the day the second fax was sent the first neurosurgeon wrote to the neurologist informing him of the consumer's problems and requesting a CT scan to *"evaluate his ventricular size"*. On the following day the first neurosurgeon rang the consumer's wife to assure her that he had ordered a CT scan at the first hospital.

After this telephone conversation the consumer's wife telephoned the neurologist at the first hospital about the arrangements for the CT scan. The neurologist was not aware a CT scan was required, but asked the consumer and his wife to come to the first hospital for admission to a ward that day. The consumer complied. The following day while he was having the CT scan the scanner broke down. Another CT scan was arranged at the second hospital and the consumer went to the second hospital by ambulance in early November 1997.

When the consumer and his wife arrived at the second hospital the first neurosurgeon saw them. The consumer's wife asked the first neurosurgeon whether the alteration in her husband's visual acuity would be permanent. The first neurosurgeon did not think so but thought it would take several months to right itself. The consumer's report indicates that; "[t]*he CT Scan was normal and the ventricles were small*." The consumer also had a lumbar puncture that showed his intracranial pressure was low. The neurosurgical team doubted that the consumer would tolerate a pressure this low and they recommended that an in-line valve be inserted.

Three days after his transfer to the second hospital the consumer had a split valve inserted into the previous shunt by the first neurosurgeon at the second hospital. The consumer was discharged six days later.

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

The second ophthalmologist saw the consumer again in early December 1997 and referred the consumer back to the second neurosurgeon, because his vision had deteriorated since his shunting procedure. There also appears in the consumer's general practitioner file an unsigned letter of referral, dated the same day, for the consumer to see a neuro-ophthalmologist. This referral letter contains a hand written note indicating that the consumer decided against the referral.

Ten days later the consumer's GP referred the consumer to the first ophthalmologist because of a deterioration in his visual acurity. Following examination the first ophthalmologist reported to the consumer's GP on the following day that:

> *"I believe* [the consumer] *has consecutive optic atrophy with papilloedema with visual field and visual acuity lost. He still has persisting papilloedema in spite of a successful lumbar peritoneal shunt and I believe this now represents a compartmental syndrome, i.e. although the CSF pressure has been lowered, there is still localized pressure effect from the pressure at the distal end of his optic nerves.*
>
> *I would recommend that he should have his automated visual field analysis repeated to confirm further progression of field loss and then should go on to have optic nerve sheath decompression initially to the left eye and also probably to the right eye.*
>
> *I have explained very carefully to* [the consumer] *and his wife that this is a procedure with a few recognised complications but the major consideration in this situation would be the fact that the optic nerves already show marked damage and it would not surprise me if optic nerve sheath decompression could do little more than hold the vision at the present level. He may however be somewhat fortunate and get an improvement in visual function bi-laterally after this surgery."*

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

In early January 1998, the second neurosurgeon responded to the second ophthalmologist's letter:

> *"I write in reply to your letter dated* [early December 1997] *concerning this patient, who has been treated with benign raised inter cranial pressure with a shunt system, and later have a valve place in the shunt system to control presumed low inter cranial pressure.*
>
> *I understand from* [the first neurosurgeon] *that you have discussed the management of this patient further since this letter was written, and I believe that the patient has been referred to* [the first ophthalmologist] *for consideration of division of the optic nerve sheath. I have previously encountered persons who have developed progressive optic atrophy despite adequate shunting of a benign raised inter cranial pressure system, and I believe that division of the optic nerve sheath would be the correct cause of action for* [the consumer]. *I would be interested to hear any further comments about this."*

The second neurosurgeon advised the Commissioner that:

> *"As well recognised the underlying cause for persons presenting with benign raised inter cranial pressure and papilloedema is uncertain, the management hinges upon two areas:*
>
> *The first is attempting to restore normal inter cranial pressure using a cerebro spinal fluid shunting procedure, and the second is to decompress the optic nerve sheets themselves.*
>
> *Recognising from* [the second ophthalmologist] *that* [the consumer's] *vision was continuing to deteriorate despite the shunt procedures, I discussed the situation with* [the first ophthalmologist], *and* [he] *agreed to perform optic nerve sheath decompression procedures.*
>
> *I believe however that despite these various forms of intervention in some situations progressive optic atrophy does appear to continue with on going visual loss.*

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

I would also comment that I did discuss with the family the possibility of monitoring the inter cranial pressure with an implanted transducer, and it was my impression that initially they accepted this advice and a request for urgent admission was made to [an] *area in March of this year. However, when* [the consumer] *was contacted I understood that he declined to accept this form of invasive monitoring."*

The first ophthalmologist cannot recall any decisions between himself and the second neurosurgeon about the consumer prior to his surgery.

In early January 1998 the first ophthalmologist performed optic nerve sheath decompression on the consumer's left eye. The consumer was discharged two days later and on the following day the first ophthalmologist reported to the consumer's GP that:

> *"A brief note to let you know how* [the consumer] *has fared following his left optic nerve sheath decompression that was performed under G.A. at* [the second hospital] *on Tuesday morning. ... Currently I am optimistic that the surgery may have produced some benefit to his vision."*

In mid-January 1998 the first ophthalmologist further reported to the consumer's GP that:

> *"I had the pleasure to review eight days following routine left optic nerve head decompression... and plan review in three weeks time. At that stage we will make a decision as to whether he should go ahead with decompression surgery on the right side."*

In early February 1998 the consumer and his wife attended the second neurosurgeon's neurosurgery clinic at the first hospital where the registrar reported:

> *"I am pleased to report that his headaches are significantly improved to the point where he suffers only occasional minor headaches. His visual fields have continued to deteriorate, I reviewed the correspondence from* [the first ophthalmologist] *and I understand that* [he] *has performed a left optic nerve fenestration on* [a date in early January 1998].

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

From a neurosurgical point of view I think there is little else for us to do. I think that [the consumer] *requires a primary care physician who will manage his benign raised inter-cranial hypertension and who will consult the appropriate specialist should he develop any of his symptomotology…* [The consumer and his wife] *are rather upset about several aspects of their care and they were able today, to ask* [the second neurosurgeon] *several questions. Unfortunately time precluded an in depth discussion with* [the second neurosurgeon] *and* [the consumer's wife] *is planning to put those questions to him in writing. She also has several questions for* [the first neurosurgeon] *and will write to him as well. I understand she also has several questions for* [the neurologist].

It is unfortunate that [the consumer] *has suffered this condition in a male his age and that the placement of a lumbo peritaneal conduit was complicated by low pressure headaches. It is also disheartening that he has significant visual loss."*

The second neurosurgeon advised the Commissioner that:

"In response to [the consumer and his wife's] *conversation with the registrar* [in early February 1998] *when they thought they would see* [the second neurosurgeon]. *The outlying clinics in centers such as* [three cities] *are frequently large clinics with thirty or forty patients attending the clinic, and the clinics are usually run by a team of persons including a neurosurgical consultant and registrar. The clinic would be under the name of the consultant, but I don't believe patients are advised whether they will be seeing the consultant, the registrar or other members of the neurosurgical staff."*

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

The consumer and his wife considered the second neurosurgeon arrogant because he ignored their questions. However, the second neurosurgeon advised the Commissioner that:

> *"At the time of particular clinic in* [the first hospital] *the registrar who came to the clinic* […], *attempted to answer the many questions the family posed and then asked me to come to see the family as well. This I did and spent some time in the clinic with* [the consumer and his wife], *the time spent being considerably above the period of time normally spent interviewing patients. I recognize that there were numerous other persons waiting to be seen at the clinic, and hence suggested that the questions that* [the consumer and his wife] *were posing had not been answered, they would fax the questions to me and I would attempt to answer them.*
>
> *I am sorry that* [the consumer and his wife] *took exception to aspects of the service they received. It was certainly not my intention to be arrogant or unhelpful and I responded to all of their concerns in an appropriate manner and time frame."*

In early February 1998 the consumer and his wife faxed the second neurosurgeon a letter containing approximately twenty questions. The second neurosurgeon advised the Commissioner that:

> *"A list of queries that appeared critical of the management that* [the consumer] *had received was faxed to the department, and I attempted to reply to these questions, reply being completed* [in late] *February1998. This was forwarded to* [the consumer] *and I was not informed that he had not received the reply."*

The second CHE's complaints co-ordinator forwarded the second neurosurgeon's letter to the consumer's wife in March 1998.

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

Early February 1998 the first ophthalmologist reported to the consumer's GP that one month following a routine left optic nerve decompression that:

> *"At this stage I would prefer to pursue a conservative approach rather than rushing in to optic head nerve decompression for his RE* [right eye]. *We plan to review* [the consumer] *in two weeks time with repeat automated visual feel analysis and the question of whether to proceed to optic nerve head decompression on the right side will then be discussed at this time."*

By mid-February 1998 the first ophthalmologist again reported to the consumer's GP that:

> *"I believe the best option to try and preserve the remaining visual function on the right side is optic sheath decompression. I have arranged to perform this, this coming* [date in] *February. I will discuss this case further with* [the second neurosurgeon] *before this time."*

A copy of all the first ophthalmologist's letters were sent to the second neurosurgeon. The consumer underwent optic nerve decompression of the right side in early February 1998.

In early March 1998 the consumer and his wife received a response to their letter to the neurologist in which he answered:

> *"Normally in people with benign inter-cranial hypertension we give them a good trial of treatment and one could have made grounds for having carried on with steroids as between 23-09-97 and 07-10-97 the pressure had dropped for the first time. However, it was a slow resolution if anything of the papilloedema that was concerning me mostly.*
>
> *I would like to say, that this referral to the neurosurgical unit was made faster in terms of benign inter-cranial hypertension, most of our cases being monitored for a longer period, even when they have papilloedema, although always there is some resolution in papilloedema.*

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

As far as frequency of assessment is concerned, I do not think anyone can give a clear cut answer but in the past out patients have been assessed a few weeks apart. [The third ophthalmologist] *will be able to give you his own perspective. He would have noted, I suspect that your vision had not deteriorated between the times you saw* [the second ophthalmologist] *for the first time on the* [a date in mid-July 1997] *and the first time you saw* [the third ophthalmologist in early September 1997]. *Please note that he decided to monitor you himself.*

The usual pattern in chronic papilloedema, is for visual fields to shrink over a period of time, although there is always a risk of rapid loss of vision, this is very uncommon, and I would have certainly not come across it. I think it would be fair to say that as you were on treatment we were all expecting things to resolve. Although visual field assessment can detect a sequential loss, we do depend on patients to record any sudden change in their vision if this happens. Once vision does start to change then that needs appropriate assessment and management.

Follow up in the [region] *is never a problem and I for one am more that happy to respond immediately if the case demands as will happen on the day you were trying to contact me. On returning home that day, I learnt that my receptionist had left a message that you had been trying to contact me. After speaking to you, an admission was arranged to* [the first hospital]. *Of the three of my patients who have had shunts performed, none of them have returned to my care as on each occasion their pressures and papilloedema have favourably responded to the shunt. As installing the shunt is the last straw in reducing the pressure and therefore the papilloedema, any problems arising soon after the shunt is inserted are most likely, and are often related to the shunting procedure itself and do require close follow up by the neurosurgeons.*

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

In response to your question number 17, I must admit that I have not come across visual failure following shunting procedure. We were always concerned about impairment of sight, but more from a sudden haemorrhage from the raised pressure and I believe that this was discussed with you on more that one occasion, particularly during the three days admission when [the consumer] *expressed his view that he had very little by the way of serious symptoms – why did he have to stay in. I remember telling* [the consumer] *at that stage that there was risk of sudden changes, particularly haemorrhage causing loss of sight.*

You also raised the question of the initial diagnosis being right or wrong. After having discussed with you my concerns that [the consumer's] *gender and age was slightly unusual, I had satisfied myself that we were dealing with benign inter-cranial hypertension, in particular as the MRI scan has been normal. It has been reported by a radiologist in* [the second city] *and we had also discussed this scan in our radiology meeting here. Further more the spinal fluid composition was entirely within normal limits, alerting me to no other possibility that needed pursuing. Surgical intervention that* [the first ophthalmologist] *has undertaken is again along the lines of treating benign inter-cranial hypertension and a diagnosis in which I understand, (*[the first ophthalmologist]*) is also in agreement."*

The consumer and his wife provided the Commissioner with information that there are two accepted surgical treatments used to treat benign intercranial hypertension. One is optic nerve fenestration and lumbar-peritoneal shunting. The neurologist informed them that the only course of treatment was insertion of a shunt and optic nerve fenestration was not discussed as an alternative form of treatment when the consumer did not respond to medical treatment. (Ref: Mr Michael Wall, University of Iowa Department of Neurology and Department of Optalmology and Visual Science *http://webeye.ophth.uiowa.edu/dept/iih/pc-index.htm.)*.

The consumer and his wife argue that they were therefore not fully informed of the treatment options available before the neurologist referred them to the neurosurgical team.

Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

The neurologist advised the Commissioner:

> *"As benign intracranial hypertension is an uncommon condition, it is very prone to variations in standard of practice which differs from one part of USA to another. Hence the document you have provided can not be taken to imply that those views are accepted by practitioners in other parts of USA and more importantly in New Zealand. Most cases with this condition (benign intracranial hypertension) in New Zealand and the U.K. and I believe in Australia are referred to a neurologist.…*
>
> *Although nearly all of my neurology colleagues in New Zealand are well aware of the claims made by some of the American eye surgeons, this practice has not been widely adopted for obvious reasons. Mainly, as the most important concern in these patients is to lower the intracranial pressure, the best method in achieving this aim is chosen. The only time tested method of lowering the pressure is of providing a form of drainage to the spinal fluid, an area in which neurosurgeons specialise and neurologists familiar with the various clinical conditions, their diagnoses and management. The premise that optic nerve surgery is as beneficial as shunting has never been scientifically tested.*
>
> *Current opinion is that the effects of optic nerve sheath decompression are short lived (weeks) and so the procedure is best reserved for situations where there appears to be an acute or rapid decline in vision. The long term effects of this procedure, beneficial or deleterious are not well documented.* [The consumer's] *vision was stable and normal at the time he was seen by the neurosurgical unit.*
>
> *The fact that this procedure has made no difference to the persistent rise in the spinal fluid pressure in* [the consumer's] *case is sound support for the argument that as a primary surgical treatment tool, this procedure is not very good."*

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Information Gathered During Investigation, *continued*

The neurologist advised that the general view held by his New Zealand colleagues:

> *"…*[I]*n a case in whom medical treatment had failed and the vision unimpaired, the treatment of choice was a shunting procedure. Again all of them shared the same view that the optic nerve decompression should be reserved only for patients with evolving loss of vision."*

The neurologist also advised the Commissioner that he also sought an overseas opinion. He telephoned his professor at the hospital where he did his training in neuro-ophthalmology to ask his opinion. The professor responded:

> *"*[T]*hat he had never come across an optic nerve sheath procedure being performed in a person with normal vision. He would be very anxious for any one to touch a healthy optic nerve in case the nerve got damaged and would only entrust such a procedure to a person who was well versed with the technique…*
>
> *I honestly do not believe that the practice in this field will change significantly as we have to be accountable for our actions both from a scientific point of view and from the patient well being and safety point of view. Most of us would require to be convinced by the results that such a procedure is beneficial and complication free in the longterm before embarking upon a major revision in our practice."*

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Advice to the Commissioner

The Commissioner sought the advice of a neurosurgeon on a number of issues raised in this investigation:

- **Visual Loss and benign inter-cranial hypertension**

Severe visual defects develop in four to twelve percent of cases. It may be of sudden of gradual onset and there is no clinical feature that predicts its progression.

- **Normal course of treatment for Intercranial Hypertension**

The accepted practice in treating benign inter cranial hypertension is to start with medical treatment in the form of a diuretic, either *diamox* or *furosemide*. If this is ineffective steriods (either *dexamethazone* or *prednisone*) and also serial lumbar punctures. If there is not the desired response than a lumbo-peritoneal shunt is established followed by optic nerve sheath decompression that may reverse or stabilise visual deterioration.

- **Whether the consumer's treatment conformed to this practice**

The Commissioner was advised that failure of the shunt to relieve the pressure around the optic nerve is not a common complication of this operation. After reviewing all the information the consumer received an appropriate standard of care according to the current accepted international standards.

Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

...

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.

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. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

...

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; and*
- *c) Advice of the estimated time within which the services will be provided; and*
- *d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and*
- *e) Any other information required by legal, professional, ethical, and other relevant standards; and*
- *f) The results of tests; and*
- *g) The results of procedures.*

Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Code of Health and Disability Services Consumers' Rights, *continued*

2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about –

a) The identity and qualifications of the provider; and

b) The recommendation of the provider; and

c) How to obtain an opinion from another provider; and

d) The results of research.

…

Opinion: No Breach The Neurologist

In my opinion the neurologist did not breach Right 4(2), Right 6(1)(b) or Right 6(3) of the Code of Health and Disability Services Consumers' Rights as follows.

Right 4(2)

The neurologist followed the accepted medical management for the consumer's benign intracranial hypertension. When the consumer's condition did not respond to treatment as expected the neurologist referred him for surgical assessment. The neurologist knew the consumer had already seen two eye specialists and in these circumstances the accepted course of treatment was a surgical referral.

The neurologist did not know that the first neurosurgeon had referred the consumer for a CT scan. However as soon as he received this information from the consumer, the neurologist asked him to come to hospital immediately and the CT scan was performed the following day. When the scanner broke down the neurologist arranged for the consumer and his wife to proceed immediately to the second hospital. The second hospital performed the scan the day after arrival. I accept the independent neurologist's advice that the neurologist treated the consumer in accordance with international standards.

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Opinion: No Breach The Neurologist, *continued*

Right 6(1)(b)

The neurologist was the consultant responsible for the consumer's care after the referral from the GP. The neurologist referred the consumer to the neuro-surgical team for three reasons. First, the primary aim of treatment in the consumer's case was to reduce the cerebro-spinal pressure by the insertion of a valve shunt, as medication and lumber puncture treatment had been unsuccessful. At the time the neurologist referred the consumer to the neuro-surgical team the consumer's visual acuity was normal. In such circumstances optic nerve decompression is not the accepted course of treatment because its benefits have not been scientifically substantiated. Therefore, for these reasons, at the time the neurologist referred the consumer for review by the neuro-surgical team he did not fit the criteria for optic nerve decompression and he did not discuss these treatment options with the consumer and his wife. In my opinion this decision was reasonable in the circumstances.

Right 6(3)

The neurologist answered the many questions asked of him by the consumer and his wife. In some instances this took some time but in my opinion there was no undue delay. The neurologist's actions were reasonable in the circumstances.

Opinion: No Breach - The Second Neurosurgeon

In my opinion the second neurosurgeon did not breach Right 4(5), Right 5(1), Right 6(1) or 6(3) of the Code of Rights.

Right 4(5)

The second neurosurgeon took reasonable steps to respond to requests for information from other health professionals. The second neurosurgeon responded to the second ophthalmologist about one month after he had seen the consumer. The consumer's medical records contain extensive documentation of his referrals. If there was a more urgent need for this information one or other of these professionals could have communicated by telephone. The evidence indicates the second neurosurgeon co-operated with the other professionals treating the consumer.

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Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Opinion: No Breach The Second Neurosurgeon, *continued*

Rights 5(1) and 6

The first hospital does not have a neurosurgeon on staff and relies on visiting specialists to provide services. The second hospital's neurosurgeons operate several outpatient clinics in the region. The consumer and his wife expected to see the second neurosurgeon at their outpatient appointment at the first hospital. Unfortunately the second neurosurgeon was unable to see every patient booked for that day and his registrar saw the other patients. This is common practice in many hospitals in New Zealand. While the second neurosurgeon did not examine the consumer he did make himself available to answer the questions the registrar was unable to respond to.

The second neurosurgeon spent time with the consumer and his wife but was conscious that he had other patients to see that day. To balance the demands placed upon him he suggested an alternative which was to put their additional questions in writing. In my opinion this was reasonable. The second neurosurgeon answered the consumer's fax in a lengthy letter about three weeks after he received it. The letter was sent to the second hospital's healthcare complaints co-ordinator who forwarded it to the consumer and his wife. While there was a delay in this occurring this was not through any action or inaction on the second neurosurgeon's part.

Opinion: No Breach - The First Neurosurgeon

In my opinion the first neurosurgeon did not breach Right 4(2) or Right 6(1) of the Code of Rights.

Right 4(2)

The first neurosurgeon did not refer the consumer to specialist opthamology services. He saw the consumer as a part of the neurosurgical team. The first neurosurgeon confirmed that the insertion of a shunt was an accepted form of treatment aimed at reducing intracranial hypertension. When the consumer did not respond as expected the first neurosurgeon arranged for a CT scan at the first hospital to assess the likely cause. At the same time the consumer was seeing the second ophthalmologist, the neurologist and his GP who referred him to the first ophthalmologist. I note that the consumer was to be referred to a neuro-ophthalmologist in December 1997, but he decided against it. In my opinion the first neurosurgeon was following an accepted course of treatment and his action were reasonable in the circumstances.

I accept the advice on my independent neurologist that the first neurosurgeon's actions met professional standards.

Neurosurgeon / Neurosurgeon / Neurologist

Report on Opinion – Case 98HDC14086, continued

Opinion: No Breach - The First Neurosurgeon, *continued*

Right 6(1)

The consumer was under the care of the neuro-surgical team as well as other health professionals. I am advised by two neurosurgeons that the type of surgical procedure performed by the first neurosurgeon is straightforward and relatively minor in terms of that particular speciality. While this is so, the procedure is nonetheless one which carries risks and requires a period of post-operative convalescence to ensure that the shunt is operating properly. The first neurosurgeon advised me that it is doubtful that he would have advised the consumer that he would be back at work in five days. I am unable to conclude on the information provided to me that the first neurosurgeon did not fully inform the consumer about the procedure and its likely outcome. Further, there is no evidence that visual impairment was not discussed with the first neurosurgeon. The consumer was experiencing visual problems prior to seeing the first neurosurgeon and I am unable to conclude that they were not also discussed with the first neurosurgeon.

During the course of the consumer's treatment he consulted several members of the neuro-surgical team. There is no evidence that the explanations he received regarding the likely post-operative outcome were in conflict. The neurologist, the second neurosurgeon, the first neurosurgeon and my independent neurosurgeon advised me that in their opinion raised intracranial hypertension usually responds to surgical intervention and that the consumer did not respond as expected. I have received no information, which suggests that the first neurosurgeon did not fully inform the consumer about the post-operative difficulties. I also note that the first neurosurgeon responded to the consumer and his wife's requests for further information when they were made.