Laser eye surgery and informed consent for change of treatment plan
16HDC00083, 9 March 2018

Ophthalmologist ~ Registered nurse ~ Laser eye surgery ~ Vision correction ~ Informed consent ~ Rights 4(1), 5(2), 7(1)

A woman underwent laser eye surgery at a laser eye surgery clinic (the clinic). The surgical treatment plan was to correct the left eye for long distance vision by creating a thin flap, and to create a thick flap in her right eye and place a KAMRA inlay underneath the thick flap to improve her near vision. The woman provided written consent for this treatment plan and consented to receiving the KAMRA inlay in her right eye.

After receiving her consent, the ophthalmologist proceeded with the surgery; a registered nurse programmed the laser machine. The nurse accidently programmed the thick flap in the woman's left eye. The ophthalmologist and the nurse have differing recollections of whether a cross-checking procedure occurred. The ophthalmologist created the flap in the woman's left eye with the laser.

When the ophthalmologist realised the error, he stopped and took some time to consider what to do, before talking to the woman about it. The ophthalmologist told HDC that he then informed the woman of the options available to her, and believed he obtained her consent to proceed with the KAMRA inlay in her left eye. The ophthalmologist then inserted the KAMRA inlay into her left eye.

Findings
By failing to ensure that the correct flap measurements were programmed into the laser machine, and by not detecting this error prior to commencing the procedure, the ophthalmologist failed to provide services to the woman with reasonable care and skill, and breached Right 4(1).

Pursuant to Right 5(2), the woman had the right to an environment that enabled her and the ophthalmologist to communicate openly, honestly, and effectively. In the circumstances of this case where the change in procedure was not due to an emergency, mid-procedure was not an appropriate environment for the ophthalmologist to seek the woman's informed consent for the change in procedure, and did not allow for effective communication. Accordingly, the ophthalmologist breached Right 5(2).

Right 7(1) states that services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent. Because the ophthalmologist discussed the change in procedure with the woman during the surgery, while she was sedated, she was not able to give adequate consideration to whether she wanted to have the KAMRA inlay inserted in her left eye, and was not in a position to give her consent to the change in procedure freely. Accordingly, the ophthalmologist also breached Right 7(1).

Adverse comment was made about the nurse not programming the laser correctly. However, it was considered that the ophthalmologist, as the supervising ophthalmologist performing the surgical procedure, had the responsibility to ensure that the measurements were correct.

It was found that the errors that occurred did not indicate broader systems or organisational issues at the clinic, and that the clinic took reasonably practicable steps to prevent the errors

occurring. The clinic was not found to be directly liable, or vicariously liable, for the ophthalmologist's breaches of the Code.

Recommendations

It was recommended that the ophthalmologist undertake further training on informed consent processes and effective communication, and provide evidence of attendance at such a course. The ophthalmologist provided evidence of having done so. It was also recommended that he provide a written apology to the woman for his breaches of the Code.