Opthalmologist

Opthalmologist

Report on Opinion - Case 97HDC4935

Complaint

A woman complained to the Commissioner about treatment her uncle ("the consumer"), received from the provider, an ophthalmologist.

The complaint was as follows:

- *In late 1996, the consumer consulted the provider because he was troubled with bad sight in his right eye. The provider diagnosed a detached retina in the right eye and said nothing could be done for it. The provider identified a slight leakage behind the left eye and said he could do a laser treatment on the left eye. However there was no guarantee of success. At no time was the consumer told the laser treatment carried the risk that he might lose his sight completely.*
- *The consumer had two lots of laser treatment from the provider. Before both treatments the consumer was given a consent form to sign and he did not read it properly before signing it, due to nerves.*
- *After the first laser treatment, the consumer lost a portion of his sight and at a subsequent visit to the provider the consumer was not given due respect or communicated with properly. He was treated in a rude and abrupt manner when he asked questions.*
- *Following the second laser treatment the consumer lost his sight in the left eye almost completely. He now cannot read, watch television or drive.*
- *The treatment provided by the provider cost $800.00, which the complainant said added "insult to injury".*

Investigation

The Commissioner received the complaint from the complainant on 24 March 1997 and an investigation was undertaken. Information was obtained from:

The Complainant / Consumer's Niece
The Consumer
The Provider / Ophthalmologist

The consumer's relevant medical records were obtained and viewed. The Commissioner sought the independent advice of an ophthalmologist.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Outcome of Investigation

In July and August 1996, the consumer, then aged 77 years, noticed problems with the vision in his right eye. In September 1996, he sought the advice of an optometrist, who referred him to the provider, an ophthalmologist. A consultation was arranged.

First consultation

The first consultation with the provider was in early September 1996.

The consumer's account of this visit is as follows:

The consumer had drops put into both of his eyes. He wondered why drops had been put in his left eye, when he had come to be seen about his right eye, but he did not query this. After examining his eyes, the consumer said that the provider told him that nothing could be done for his right eye. The consumer thinks the provider said something about the retina in his right eye having slipped or become detached. However, the consumer said that the provider told him that he could do something for the left eye with laser treatment. The consumer said that the provider told him that sometimes the laser treatment did not work, but he did not say that laser treatment could lead to a deterioration of sight. The consumer tried to ask the provider questions during the consultation and was told "just to sit there and do not ask questions… I will be asking the questions."

The provider's account of the consumer's first visit is as follows:

> *At that examination I found [the consumer's] vision to be markedly reduced in his right eye at 6/60 part and his left eye was mildly reduced at 6/12. Early cataract was evident not affecting vision and the problem with his eyes related to bilateral macular degeneration. In the right eye there was a central disciform scar and in the left eye there were early degenerative changes with a haemorrhage near the centre of his eye and colloid and pigmentary changes.*

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Outcome of Investigation, *continued*

[The consumer] was therefore at risk of the left eye deteriorating due to this macula degeneration in the same way as the vision in his right eye had deteriorated with a loss of central vision which would then affect both eyes. Fluorescein angiography was indicated to detail the vascular changes of the left eye which can be helped with laser photocoagulation…

The consumer was offered either private or public hospital referral to obtain the fluorescein angiography. The consumer elected to be seen at a public Hospital. He was referred to the Eye Department that day and an angiogram was undertaken in mid-October 1996.

The provider received the angiogram taken at the Hospital at the end of October 1996 and reported on this in his capacity as Visiting Surgeon to the Eye Department at the Hospital. He wrote to the consumer on that day advising him that the angiogram confirmed:

> *… the leaking vessels in the left eye and I would recommend laser treatment to try and prevent further deterioration to the central vision of the left eye. I presume that you would like this done at [the public] Hospital and an appointment will be sent to you for the laser.*
>
> *If you wish the laser to be done sooner I could do it at [a private clinic] but the cost would be of the order of $800.00.*

The consumer decided to proceed with laser treatment privately.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Outcome of Investigation, *continued*

First laser treatment

The consumer next saw the provider in early November 1996 at the provider's private clinic. The provider advised the Commissioner that prior to carrying out the laser treatment, he told the consumer about the treatment's aim, which was to seal the leaking vessels and to prevent further deterioration in the left eye. He also told the consumer that the success of the treatment could not be guaranteed. The provider said he also informed the consumer that one third of patients treated deteriorate further from the condition despite the treatment and that sometimes repeat laser treatment is necessary if the area does not seal completely. Following this explanation the consumer signed a consent form and *"166x200 micron burns with the green only option were applied to the leaking area."*

Following Treatment

Nine days later the provider saw the consumer for a follow-up consultation. The provider's notes record that the consumer's vision was being maintained at 6/12 in his left eye and the laser scars were evident at the area of treatment. It was the provider's opinion that the consumer had had a good response to the treatment, that the vessels were sealed and that the consumer would maintain the central vision in his left eye. The provider gave the consumer a form stating that he was eligible for a driving licence with 6/12 vision in the left eye. A letter from the provider to the consumer's general practitioner states:

> *I have warned him that there may be further deterioration in the future and he should consult immediately should he notice any problems.*

In mid-December 1996 the consumer again consulted the provider as the vision in his left eye had started to deteriorate again. Upon examination, the provider found that adjacent to the area of laser treatment there was a further extension of the leaking vessel. Two days later the provider carried out fluorescein angiography at his private clinic at no cost to the consumer. This confirmed that the leaking vessels (subretinal neovascular membrane) had extended and the area of leakage was much closer to centre. The provider considered that this was amenable to further laser treatment but the risks of further extension were greater with this recurrence.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Outcome of Investigation, *continued*

Second laser treatment

Three days after that, the provider proceeded with further laser treatment to the consumer's left eye. The provider advised the Commissioner that he told the consumer of the risks of further laser treatment. In particular, the provider said he warned the consumer that because of the extent of the leaking area the laser would need to be quite extensive and there would be some permanent effect on his vision but that would be less than leaving the condition to extend of its own accord. The consumer signed a further consent form for the laser treatment and the large membrane was treated with *"287x200 and 100 micron burns."*

The consumer advised the Commissioner that the scheduled appointment time was 5.00pm but the provider did not see him until 6.00pm. The consumer was worried about the deterioration in his eyesight and once admitted to the consulting room, he tried to ask the provider questions about this. The provider was very abrupt and said something like "I have been here since seven o'clock this morning and my nerves are frazzled". He also said, "Look… I am doing my best for you." The consumer did not want to upset the provider further and waited for the provider to "cool down" and did not pursue his questioning of the provider. Before proceeding with the treatment, the provider tapped the consumer on the knee and asked, "Are we still friends?" The consumer said the provider did not tell him about any risks of treatment. He did not tell the consumer that there was a higher likelihood that this second treatment would not be successful. He did not tell the consumer that there would be some permanent reduction in sight as a result of the second treatment that required laser burns very close to the centre of the macular. The consumer says he would not have had the treatment if he knew there were any risks involved. He thought that if the treatment failed, "it is just the money I have lost." He thought this in respect of the first treatment as well.

At this second treatment, the consumer says the laser was on his eye for "a good five minutes" and when he pulled away from the laser, the whole room was a deep red. After this "everything went to the pack" as his eyesight markedly deteriorated.

Since this second treatment, the consumer has not been able to read, write, see television properly or drive his car.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Outcome of Investigation, *continued*

Follow up consultation, January 1997

The consumer saw the provider again in early January 1997 and his vision had deteriorated to 6/24. However, the provider was hopeful that the consumer would retain some degree of central vision.

The consumer was extremely concerned at this consultation because of the deterioration in his vision and he expressed the view that the provider had caused his eyesight to deteriorate with the treatment.

The provider wrote to the consumer's general practitioner. He said, in respect of the second treatment, that the consumer had required extensive laser and as a result:

> *… there has been some deterioration in vision but he is still retaining some central vision … hopefully as the haemorrhage clears and the eye recovers from the laser he will retain some more central vision…*
>
> *[The consumer] is not unnaturally worried about the situation and concerned about the effects of the treatment and I have explained in detail to him the difficulties of laser with disciform macular degeneration. Hopefully he is reassured…*

The provider advised the Commissioner that:

> *Unfortunately [the consumer] has a condition which we are not always successful in managing and this is certainly exemplified by his case history. Macula degeneration is a difficult condition … It is the condition and not the treatment that causes the loss of vision and whilst [the consumer's vision] deteriorated further after the second laser treatment, the eye was already deteriorating from the recurrence of the leaking and bleeding blood vessels. Unfortunately treatment is always less effective with recurrences of the condition …* [In the consumer's case] *there was a recurrence of the vessels from the edge of the treated area and this is not an uncommon event and produced the deterioration that occurred… This was explained to [the consumer] but unfortunately the treatment did not seal the vessels and so the condition continued to deteriorate … The problems that he has experienced need to be kept in context with the problems of the condition.*

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Outcome of Investigation, *continued*

The provider suggested that he see the consumer again in February 1997. No appointment was made, and the provider has not seen the consumer since.

The consumer paid $880.00 in total to the provider for the treatment he received. This included the initial consultation, 2 laser treatments, angiography and follow up consultations.

Consent forms

Prior to each laser treatment, the consumer signed consent forms. The forms are headed "Patient Authorisation for Surgery". The first form says:

> *I **[consumer's name]** accept the advice of **[the provider]** and agree that I have received a reasonable explanation of intent, alternatives, risks and likely outcomes, of the operation **left retinal laser** and I request that this be carried out on myself...*[the words in bold are hand written]

The second form is identical except that the name of the operation is "left laser". The consumer signed both forms.

The consumer says that he was unable to read the consent forms prior to signing them. At the first consultation, he had had drops put in his eyes in order to dilate his pupils and he did not have his glasses on, so could not see well enough to read the form. At the second consultation, he again had the drops in his eyes and said to the provider "I have no chance of reading this" and the provider said "don't worry about it, just sign here". The consumer said the provider did not read out the forms to him.

The provider advised the Commissioner that he read the consent forms out to the consumer on both occasions, as is his practice. The provider also said he always asks patients at that point if they have any questions.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Outcome of Investigation, *continued*

The provider advised the Commissioner that:

> *I have attempted at all consultations to treat [the consumer] with courtesy and give him a full explanation of all that is required. At no time have I been rude or abrupt, but I am certain that at times I have had to ask [the consumer] to listen to me, so that I could give him full explanations of his condition. It is certainly a difficult time when one is facing the loss of central vision which means that one cannot read or drive a motor car and I understand his concern but equally I have to be sure that he listens to my explanations.*

Advice from Independent Ophthalmologist

The Commissioner sought the advice of an independent ophthalmologist in the course of the investigation. The ophthalmologist advised the Commissioner as follows:

> *I note from [the provider's] clinical records ... that [the provider] observed some haemorrhage adjacent to the left macula, a finding which quite properly made [the provider] arrange for a fluorescein angiogram. Further, on viewing the fluorescein angiogram I agree with [the provider] that it was correct to advise [the consumer] to have laser treatment, as this would reduce the chance of further deterioration…*
>
> *... from the evidence available to me I consider that the treatment [the consumer] received was entirely appropriate ...*
>
> *Unfortunately, macular degeneration is the commonest cause of poor eyesight in elderly people. In most cases it cannot be treated at all. In a minority of cases, when new vessels are observed on fluorescein angiography which are a little removed from the centre of the macula, laser treatment can be used. Laser treatment may reduce the chance of further deterioration, but further deterioration often occurs despite the laser treatment. Unless there is a specific complication from the laser treatment, and there is no evidence that this was the case with [the consumer], it is not the laser treatment that causes the further deterioration. Rather, it is the natural course of the condition.* [my emphasis]

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Outcome of Investigation, *continued*

The Commissioner then arranged for the consumer to be seen by the ophthalmologist to ascertain whether "there was a specific complication of laser surgery." The consumer was seen by the ophthalmologist in mid-May 1998 and a further report to the Commissioner followed, which included the following comments:

> *When I examined [the consumer]… his vision was very poor in both eyes. It measured 3/60 in each eye. The cause of the poor vision was advanced macular degeneration in both eyes, also known as disciform degeneration…*
>
> *... [the consumer's records] indicate that [prior to laser treatment] the left vision was reduced to 6/12. At this level it is just possible to obtain a driving licence and it is also just possible to read small print. However it is still not normal vision. The aim of the laser treatment was to seal the abnormal leaking vessels that have been identified on the fluorescein in an attempt to prevent further worsening in the left eye. The success of the treatment can never be guaranteed ... The natural history of this condition is that the vision continues to deteriorate and this may occur despite laser treatment …*
>
> *At that time [after the second laser treatment] the left vision was recorded as 6/24. Although this vision was worse than the 6/12 before the laser treatment, it nevertheless was much better than it is now ... The clinical record of […] January does show some bleeding in the retina, but not enough to cause the vision to go red and not enough to cause the vision to be as poor as it is now …*
>
> *My opinion is that the natural course of the disease caused the sub-retinal neovascular membrane to continue to grow despite the laser treatment and that this resulted in the vision continuing to worsen to its present low level. Nevertheless the vision did fall from 6/12 to 6/24 after the second laser treatment …*

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Outcome of Investigation, *continued*

My examination findings on […] May do not enable me to say whether or not there was a complication of laser treatment. The eye has the typical appearance of suffering from advanced disciform macular degeneration. I think it is reasonable to conclude that the left vision would have deteriorated to its present level with or without laser treatment …

… Laser treatment for macular degeneration is done to reduce the chance of the vision worsening further from the natural course of the disease. It achieves this by destroying abnormal new blood vessels. It is the growth and bleeding of such vessels that cause the eyesight to deteriorate. Sometimes, even often, the new blood vessels continue to grow despite the laser treatment and I think this is what has happened with [the consumer]. However occasionally complications can occur from laser treatment. One is bleeding. A small amount of bleeding may have occurred in [the consumer's] eye but I do not think it was a major issue. Another is that a laser burn is inadvertently placed on the centre of the macular. This did not occur. Another is that laser burns placed, as they occasionally need to be, very close to the centre of the macular may cause some swelling which affects the vision but which usually improves. This possibly happened in the case of [the consumer].

The ophthalmologist concluded his report with the observation that:

[The provider] is a sub-specialist in medical retina conditions and their laser treatment, and he probably has more experience in managing these conditions than anybody else in New Zealand.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 2
Right to Freedom from Discrimination, Coercion, Harassment, and Exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

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…

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.

2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

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;…

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

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

RIGHT 6
Right to be Fully Informed

...

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.

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Professional Standards

The Royal College of Surgeons of England

The Senate of Surgery of Great Britain and Ireland has published a handbook *"The Surgeon's Duty of Care: Guidance for surgeons on ethical and legal issues"*. The handbook is a guide to many professional colleges, including The Royal College of Surgeons of England of which the provider is a member. The handbook includes the following:

"PROTECTING THE LIFE AND HEALTH OF PATIENTS

It is the surgeon's obligation at all times to take reasonable care to act in the patient's best interests.

In doing so surgeons should:
…Diagnose and treat within acceptable limits of established skill and competence."

The New Zealand Medical Association

The New Zealand Medical Association's Code of Ethics includes the following Rules:

> *Rule 1. Practice the science and art of medicine to the best of one's ability…*
>
> *Rule 3. Ensure that every patient receives a complete and thorough examination into their complaint or condition.*

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Opinion: No Breach

Right 2

In my opinion the provider did not breach Right 2 of the Code of Health and Disability Services Consumers' Rights in respect of the fee charged for the treatment provided to the consumer. I am satisfied that the consumer was not coerced or financially exploited by the provider, and that the $880.00 fee charged was not unreasonable.

In forming this opinion I have taken into account the fact that after the first consultation, the provider made arrangements for the consumer to have the first fluorescein angiogram taken at the public Hospital. He also offered the consumer the choice of having the photographs taken privately. It was reasonable for the provider to give the consumer this choice. Further, I am satisfied that when the provider recommended laser treatment, he again gave the consumer the choice to have the treatment done at the public Hospital, or to be done sooner at his private clinic. I am satisfied that it was the consumer's choice to have the treatment done privately.

I have also taken into consideration the fact that the provider made no further charges for the second fluorescein angiogram and the second laser treatment which were done at his private clinic.

Right 4(1)

Under Right 4(1) of the Code, the consumer was entitled to have services provided to him with reasonable care and skill. In my opinion, the services provided by the provider met this standard. In forming this opinion I have relied on the independent ophthalmologist's advice set out above.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Opinion: No Breach, *continued*

Right 4(2)

The consumer was entitled to have services provided in a manner which complied with legal, professional, ethical and other relevant standards. The relevant standards are those adopted by the Royal College of Surgeons of England and The New Zealand Medical Association which are set out above. In my opinion, the provider complied with these standards.

The provider thoroughly examined the consumer's eyes, made an accurate diagnosis and concluded that to reduce the likelihood of further deterioration of the consumer's sight laser treatment was indicated.

In my opinion, and supported by my ophthalmologist advisor, the decision to offer laser treatment was an appropriate decision in the circumstances and the treatment was carried out in an appropriate manner.

Opinion: Breach

Informed consent

The informed consent of the consumer is essential before any procedure is provided to him or her. In terms of the Code of Rights, informed consent is not a one-off event, but a *process* containing three essential ingredients, namely,

- effective communication between the parties,
- provision of all necessary information to the consumer (including information about options, risks and benefits), and
- the consumer's freely given and competent consent.

These ingredients work together and are represented in the Code by Rights 5, 6 and 7 respectively. Based on the evidence provided to me, in my opinion the provider did not follow the process of obtaining informed consent from the consumer to a sufficient extent to meet the standard required by the Code of Rights. For the sake of clarity, I have referred below to breaches of Rights 5(1), 5(2), 6(2) and 7(1) separately.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Opinion: Breach, *continued*

Communication

Under Right 5(1) of the Code, the consumer had the right to effective communication in a form, language, and manner that enabled him to understand the information provided to him. In addition, under Right 5(2) he had the right to an environment which enabled both himself and the provider to communicate openly, honestly and effectively. In my opinion, the provider breached these rights.

In forming this opinion I accept the consumer's account of events which included his perception that the provider was abrupt and unresponsive to questions. When the consumer tried to ask questions of the provider at the first consultation he was told not to do so. At the time of the second laser treatment, the consumer again tried to ask questions. The provider's reaction to this was very abrupt and the consumer felt too afraid to continue asking questions for fear of "upsetting" the provider.

The provider was required to take all reasonable steps to create an environment which facilitated effective communication. In my opinion the fact that the consumer felt afraid to ask questions indicates that no such environment was achieved. The provider did not take steps to minimise the consumer's anxieties, and neither did he enable the consumer to voice his concerns freely. The environment would have increased the consumer's anxiety making it less likely that he would understand information which was being presented to him.

Information

Under Right 6(2) of the Code the consumer had the right to information that a "reasonable consumer in [his] circumstances" needed to make an informed choice or give informed consent. Right 6(1) of the Code gave him the right to information that he would expect to receive such as an explanation of his condition, and the options available to him, including the expected risks, side effects, benefits and costs of each option.

In my opinion the provider failed to provide the consumer with enough information to enable him to understand the nature of his condition and the risks and side effects of treatment, particularly in relation to the second laser treatment.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Opinion: Breach, *continued*

The provider advises that he told the consumer that treatment may not be successful. The consumer agrees that the provider advised him the treatment might not be successful. However, the consumer said he was not told that if the treatment was not successful his vision would continue to deteriorate, possibly rapidly, as it did.

The provider advised the Commissioner that he told the consumer that the second treatment would result in permanent deterioration in vision. The consumer advised the Commissioner that the provider did not tell him this. I accept the consumer's recollection/version of events in this regard.

The fact that the treatment was, in the provider's estimation, the best treatment for the consumer is not material, as there is an absolute requirement that full information be given to the consumer. The provider was entitled to give his recommendation but was required to inform the consumer of all the risks and options in order that he might make an *informed* choice.

In summary, in my opinion the provider did not provide the consumer with sufficient information in terms of Rights 6(1)(a) and 6(1)(b) of the Code of Rights. Responsibility to ensure that the consumer understood or was given information about his condition, effects and limitations of treatment and associated risks was the provider's and he did not discharge this responsibility. Accordingly, in my opinion the provider breached Right 6(1)(a), 6(1)(b) and Right 6(2) of the Code of Rights.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Opinion: Breach, *continued*

Informed consent

In my opinion the provider also breached Right 7(1) of the Code, because the consumer was unable to make an informed choice and give informed consent to the laser treatment. In forming this opinion I have considered the information provided to me in respect of the consent forms signed by the consumer. The signing of a consent form does not of itself prove that informed consent is given to a procedure, although it may be some evidence of it. The real test of whether informed consent has been given to a procedure is the extent to which the patient is informed, prior to giving consent.

There is a difference in views as to whether the consent form was read aloud to the consumer. The provider says that it is his practice to read the form to his patients, and ask if they have any questions, and he followed this procedure with the consumer. The consumer states that prior to treatment, he removed his glasses and had drops placed in both eyes before the consent form was given to him, and as a result, he could not read it properly. At the second consultation he claims he told the provider "I have no chance of reading this" and the provider said "don't worry about it, just sign here". The consumer was nervous about what was happening to him, and felt unable to ask any questions.

Having weighed up this information, it is my opinion that while the consumer decided to proceed with laser treatment because he did not want his eyesight to deteriorate further, and therefore signed the consent forms, the consumer's consent was not based on information which he understood and consent was obtained at an inappropriate time during the consultation. The consumer should have had the opportunity to listen and ask questions of the provider, then prior to the laser treatment, to take away written material and the consent form in order to decide whether to proceed. The environment in which information was imparted was not conducive to open, honest and effective communication. This hampered the ability for the provider to impart and the consumer to receive information. In addition, information given to the consumer by the provider was inadequate. Accordingly although the consumer signed consent forms he did not give "informed consent" and the provider therefore breached Right 7(1) of the Code.

Continued on next page

Opthalmologist

Report on Opinion - Case 97HDC4935, continued

Future Actions

I recommend that the provider takes the following actions:

- Apologise to the consumer for his breaches of the Code. This apology is to be sent to the Commissioner's office and will be forwarded to the consumer.
- Reviews his procedures for obtaining informed consent from consumers, particularly elderly consumers. As macular degeneration is a major cause of poor eyesight in elderly people, and the provider can expect to see many elderly patients with this condition, it is incumbent upon him to take extra care to ensure that such patients understand the nature of their condition, what the limitations of laser treatment are, and its associated risks. This would be achieved by providing written material at a consultation prior to treatment. This will better ensure that information is understood and retained, and give the consumer an opportunity to reflect on the information provided to enable the consumer to ask relevant questions prior to treatment. Adequate time for consultations to occur should also be allocated. In addition, consumers should be advised that they are welcome to bring a support person of their choice to the consultation.
- As a minimum, ensures that consumers are given the choice of reading the consent form, or having it read to them, *before* their glasses are removed or drops inserted in their eyes. Where possible the consent form should be discussed at the initial consultation and the consumer able to consider the consequences and make an informed choice.
- If the consumer wishes, make a claim on his behalf to the Accident Rehabilitation and Compensation Insurance Corporation for medical misadventure due to lack of informed consent.

The provider is to advise the Commissioner of what steps he has taken to take account of her recommendations within one month.

Other Actions

A copy of this opinion will be sent to the Medical Council of New Zealand for their information.

A copy of this opinion, with all identifying features removed, will be sent to the New Zealand branch of the Royal Australasian College of Ophthalmologists and the Royal College of Surgeons of England for distribution to all members, for their information.