Complication during eye surgery
(13HDC01345, 16 June 2015)

Senior ophthalmology trainee ~ Consultant ophthalmologist ~ Ophthalmology clinic ~ DHB ~ Eye surgery ~ Complication ~ Open disclosure ~ Information ~ Informed consent ~ Documentation ~ Rights 4(2), 6(1)(b), 7(1)

A woman was seen at an ophthalmology clinic by a senior ophthalmology trainee. The senior ophthalmology trainee was supervised by an ophthalmology consultant, who was not present at the consultation. At the consultation, the woman signed an "Agreement to Treatment" form providing that the procedure was to be a right eye cataract and epiretinal membrane peel under local anaesthetic. Shortly after the consultation, the senior ophthalmology trainee left the DHB and was replaced.

Six weeks later, the woman presented for the procedure. The woman understood that the new senior ophthalmology trainee would be observing during the surgery, and that the consultant would be the operating surgeon. In contrast, the senior ophthalmology trainee said that he clearly recalls telling the woman that he would be the operating surgeon. He said that the woman was under local anaesthetic and was fully aware throughout the surgery that he was operating.

During the procedure, the senior ophthalmology trainee inadvertently touched the Tano scraper onto the woman's retina (the adverse event). The consultant stated that the action took less than a second and occurred too quickly for him to prevent it. The consultant took over and completed the surgery.

The woman said that she asked to speak to the doctor before she left the theatre. She said that the senior ophthalmology trainee told her that there was nothing to worry about. In contrast, the senior ophthalmology trainee told HDC that, as the woman was quite anxious, he provided an explanation to the woman about the adverse event when she was just outside the operating theatre. The consultant said that he insists on senior ophthalmology trainees explaining any complications to patients themselves as part of their learning, but that he advises them as necessary.

The senior ophthalmology trainee recorded in the clinical notes that the membrane peel had been performed and there were punctuate retinal haemorrhages, but he did not document the adverse event. The only reference to the adverse event is in the woman's discharge summary. The senior ophthalmology trainee did not record the adverse event in two letters to the woman's general practitioner.

The woman stated that by the time she went for a follow-up appointment ten days after the surgery, she was sure that all was not well. She said that the senior ophthalmology trainee expressed no concern, and did not admit to anything being amiss. A month later, the consultant saw the woman privately. The woman said that the consultant confirmed that her eye had been damaged permanently during the procedure.

It was held that the senior ophthalmology trainee did not explain to the woman sufficiently that he was a trainee and that he would be carrying out the surgery on her, and did not inform her of any increased risks resultant from having such delicate surgery performed by a trainee. Accordingly, the senior ophthalmology trainee

breached Right 6(1)(b). It followed that the woman was not in a position to give informed consent and, accordingly, the senior ophthalmology trainee breached Right 7(1). The senior ophthalmology trainee also breached Right 4(2) for failing to record the adverse event adequately, and not disclosing the adverse event to the woman or her GP appropriately. Adverse comment was made about the senior ophthalmology trainee's error during surgery.

The consultant breached Right 6(1) for failing to ensure that open disclosure occurred promptly. Adverse comment was made about the consultant failing to ensure that details about the nature of the harm and any subsequent action, including disclosure to the woman, were documented in the woman's clinical notes.

Adverse comment was made about the DHB's systems.