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Conduct Unbecoming – Informed Consent

Charge The Director of Proceedings charged that Dr Andrew John Logan was guilty of conduct unbecoming a medical practitioner and that conduct reflected adversely on his fitness to practise medicine. The particulars of the charge alleged:

1.1 Dr Logan undertook Laser Assisted In Situ Keratomileusis (LASIK) surgery on both eyes of the patient without obtaining her informed consent in that he:

(a) failed to inform the patient that the degree of hypermetropia in her eyes was in excess of what was normally accepted as safe for LASIK surgery; and/or

(b) failed to adequately inform the patient of risks associated with LASIK surgery of hypermetropia in excess of four to five diopetres.

AND/OR

1.2 Inappropriately performed LASIK surgery on the patient's left eye having been informed by her that her vision following surgery to her right eye was fluctuating.

The charge was admitted by Dr Logan.

Background In October 1996 the patient was referred by her local ophthalmologist to Dr Logan to see if she would be a suitable candidate for LASIK surgery. The patient had had hyperopia (long-sightedness) since she was born. When the patient phoned Dr Logan's surgery in November 1996 to make an appointment she was told by a staff member that she would not need an appointment prior to the surgery. She was advised to stop wearing hard contact lenses for six weeks prior to the surgery and was given an appointment time.

In either November or December 1996 the patient received a two-page document from Dr Logan's surgery setting out pre-operative and post-operative instructions for the surgery. The document did not purport to set out any complications or risks associated with the proposed surgery. The patient telephoned Dr Logan's surgery three times in January in order to discuss the proposed surgery with Dr Logan. She was unable to contact Dr Logan directly and on each occasion she spoke with a staff member.

On 12 March 1997 Dr Logan gave the patient a pre-surgery examination. He told the patient that after the treatment her sight might be slightly under or over-corrected and that she may need glasses for reading. Finally, Dr Logan told the patient that the long-term effects of the procedure were unknown and he asked the patient if she had any questions. She told him that she did not know what questions to ask.

Dr Logan and the patient then went back to reception where there was a consent form on the counter for the patient to sign. The patient told Dr Logan that she had not seen the form before. The clinic's standard procedure was to send patients a patient information booklet and introductory letter about laser procedure prior to surgery. However, the patient was told by a member of staff that they had overlooked sending it out to her. Dr Logan and other staff waited while the patient read and signed the

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consent form at the reception desk. After signing the consent form, the patient went with Dr Logan and the other staff to have the treatment performed.

Following surgery the patient was troubled with pain, blurry vision and fluctuating vision. She consulted her local ophthalmologist on 27 March 1997 regarding her concerns. At that time her vision was blurry in the morning and then improved a little during the day but she could not read or see clearly.

The patient remained concerned about her vision and telephoned Dr Logan's surgery twice on 14 March 1997 and again on 24 March, 25 March and 27 March 1997. On each occasion she spoke with a staff member.

On 8 April 1997 the patient went to Dr Logan's surgery for the performance of LASIK on her left eye. At that time the patient reminded Dr Logan that she was having difficulties with her vision in her right eye. Dr Logan tested the patient's right eye noting that it was highly myopic. He told her that her right eye would settle but that he would change the treatment he had intended for her left eye. The LASIK was then performed on her left eye.

On 11 April 1997, the patient consulted her local ophthalmologist as she was troubled by pain, fluctuating vision and blurred vision in both her eyes. She had further consultations with her local ophthalmologist in April, June and July 1997. She consulted Dr Logan in July 1997 and a third ophthalmologist in September and October 1997. Since that time, the patient's vision difficulties in her left eye have settled, but she still has trouble with her right eye.

Finding The Tribunal found Dr Logan guilty of conduct unbecoming a medical practitioner and that conduct reflected adversely on his fitness to practise medicine.

The Tribunal was satisfied that Dr Logan's admitted failure to inform the patient that the degree of hypermetropia in her eyes was in excess of what was normally accepted as safe for LASIK surgery, was an unacceptable discharge of his professional obligations, of sufficient significance to attract sanction for the purpose of protecting the public, and that it constituted conduct unbecoming a medical practitioner.

The Tribunal was also satisfied that Dr Logan failed to adequately inform the patient of the risk associated with LASIK surgery or hypermetropia in excess of 4 to 5 dioptres and that it constituted conduct unbecoming a medical practitioner.

The Tribunal considered the fact that the patient contacted Dr Logan's surgery several times prior to the procedure being carried out confirmed that she did seek information about the procedure. However, she did not receive any information about the risks involved with the procedure prior to the day of the procedure being carried out. While the patient saw a consent form at the surgery, the risks listed on that form related to risks involved with a different laser procedure and referred to myopia, not hyperopia. Additionally, the Tribunal found that having the patient read the consent form while the medical staff stood by waiting to perform the procedure did not afford an adequate opportunity for her to raise any concerns or to decide whether or not to proceed to undergo the procedure.

Penalty The Tribunal took into account a number of mitigating factors. Dr Logan had apologised to the patient and had refunded her $1 650.00. He also entered a guilty plea at the earliest opportunity, thereby reducing the cost of the proceedings, as well as relieving the patient of the necessity to give evidence.

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The Tribunal considered Dr Logan had also made significant changes to his practice since the complaint was made. He no longer treats hypermetropic patients and he has reduced the upper level of short-sightedness that he will treat, significantly below what is now accepted as an upper limit of treatment by other practitioners. He had also made significant changes to his process for giving informed consent.

The Tribunal ordered that Dr Logan: be censured; fined $2 500; pay $4 670.83, being 25% of the costs and expenses of and incidental to the investigation, prosecution and hearing of the charge. It further ordered a notice of the hearing be published in the New Zealand Medical Journal.

The Tribunal was satisfied that the steps Dr Logan had taken to amend his practice appropriately addressed the factors giving rise to the charge and therefore no conditions were imposed on his practice.

The full decision relating to the case can be found on the Tribunal web site at http://www.mpdt.org.nz. Reference No: 01/85D.

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