Anaesthetist, Dr C

A Report by the

Health and Disability Commissioner

(Case 09HDC01691)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. Mrs B was admitted to a private hospital on 18 August 2009 for abdominal surgery, for a suspected ovarian mass. She had previously completed preoperative documentation, noting allergies or sensitivities to codeine and cloth sticking plasters. Nursing staff completed a preoperative checklist, and placed allergy stickers on several pages in Mrs B's clinical notes. These indicated that codeine caused Mrs B to feel "spaced out", plasters caused a rash, and also that morphine caused vomiting. "Codeine", "morphine" and "sticking plaster" were written on her patient wristband. During the pre-anaesthetic consultation with anaesthetist Dr C, Mrs B said that she did not want morphine because it had previously caused her to vomit, and that she had tolerated pethidine and tramadol in the past.

2. Later that morning Mrs B underwent surgery. For postoperative pain relief she was started on a ketamine infusion and given Parecoxib, then pethidine. On arrival in the recovery ward, she was started on a morphine PCA[1] and given Codalgin (paracetamol and codeine). Mrs B was reviewed by Dr C that evening. At that time, her main complaint was a feeling of being "spaced out". A nurse reminded Dr C of Mrs B's previous reactions to morphine and codeine, and noted that he was not concerned. The rate of the ketamine infusion was reduced.

3. Mrs B's postoperative course was marred by episodes of nausea and vomiting, despite the use of antiemetics. Because of this, she declined analgesia other than paracetamol from the first postoperative day. Another doctor prescribed pethidine and tramadol on the afternoon of the second postoperative day, and Mrs B began using these that evening. Mrs B was discharged home on 23 August.

Findings

4. I do not consider that Dr C provided Mrs B with adequate information in relation to his proposed plan for postoperative pain relief, or acted appropriately to obtain Mrs B's informed consent for the treatment he provided. Accordingly, I find that Dr C breached Rights 6(2)[2] and 7(1)[3] of the Code of Health and Disability Services Consumers' Rights (the Code).

[1] Patient Controlled Analgesia, administered by an infusion pump.

[2] Right 6(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] Right 7(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.

Investigation process

5. On 7 September 2009 the Commissioner received a complaint from Mrs B about the services provided by anaesthetist Dr C. She was particularly concerned about his decision to prescribe morphine when she had asked not to have this.

6. An investigation commenced on 4 May 2010. The following issues were identified for investigation:

- *Whether Dr C obtained informed consent from Mrs B for anaesthetic treatment between 18 and 23 August 2009.*
- *Whether Dr C provided adequate information to Mrs B in relation to anaesthesia prescribed between 18 and 23 August 2009.*
- *Whether Dr C provided appropriate care to Mrs B between 18 and 23 August 2009.*

7. Information was reviewed from:

Mrs B	Consumer/complainant
Mrs A	Consumer's sister/complainant
Dr C	Provider/anaesthetist
A private hospital	Provider/hospital

Also mentioned in this report:

Dr D	Anaesthetist

Independent expert advice was obtained from anaesthetist Dr Vaughan Laurenson (**Appendix 1**).

Information gathered during investigation

Background

8. In August 2009, Mrs B (then aged 63 years) was diagnosed with an ovarian mass. She saw a gynaecological oncologist on 13 August, and was advised of the need for major abdominal surgery.[4] At that appointment, Mrs B signed a "Request and Consent for Treatment" and a "Patient Registration Form". Question one of the 'Patient Health History' section on the registration form asks about allergies or sensitivities. Mrs B wrote "Codeine", causing a "spaced out" reaction, and "Cloth sticking plaster", causing eczema. She also completed an "Anaesthesia Assessment — Patient Questionnaire". This also asked about allergies, and Mrs B again wrote "Codeine".

[4] The proposed surgery included a laparotomy (surgery to explore the abdomen), hysterectomy, bilateral salpingo oophorectomy (removal of ovaries and fallopian tubes), omentectomy (removal of tissue lining surrounding the stomach and other organs in the abdomen), and possible removal of the appendix.

She noted that she had had postoperative nausea and vomiting following previous anaesthesia, and that she was a "long time coming round".

Preoperative consultation

9. At 8.30am on 18 August, Mrs B was admitted to a private hospital (the hospital). A "Preoperative Nursing Checklist" was completed. An allergy sticker was put on the checklist noting:

> "Codeine → spaced out
> Sticking plaster → rash
> Morphine → vomiting"

10. Similar allergy stickers were placed on several other pages in Mrs B's patient notes. "Codeine", "morphine", and "cloth sticking plaster" were written on her patient wristband.

11. Mrs B met with consultant anaesthetist Dr C.[5] Her sister, Mrs A, was also present. Mrs B states that she was feeling very anxious, and a bit "fuzzy", owing to the suddenness with which she had proceeded from diagnosis to surgery. She recalls showing Dr C her patient wristband, and telling him that she had previously vomited after having morphine. She told him that she had had pethidine, albeit many years ago, and tramadol for a lumbar sprain earlier in the year, both without problems. Mrs B recalls Dr C telling her that given the nature of the surgery, it was likely that she would vomit whatever form of pain relief was used.

12. Mrs B acknowledges that she does not recall the full details of her discussion with Dr C, as she was very anxious at the time. She does not recall whether they spoke about codeine, or whether he told her about the risks of anaesthesia. Her strongest recollection is that his manner was very abrupt.

13. Mrs A recalls that Dr C spoke with her sister at some length and in some depth about the anaesthesia, including the risks. She states that they discussed both morphine and codeine. Mrs A states that Dr C told Mrs B that he was going to prescribe a morphine PCA, that she told him she did not want this as morphine had made her very sick, but that Dr C disregarded her. Mrs A does not recall Dr C explaining why he intended to chart morphine, but she also remembers him saying that because of the amount of pain relief needed, Mrs B was likely to be sick irrespective of the form used. Mrs A does not recall whether, at the end of the consultation, Dr C stated explicitly that he still intended to use morphine, but in light of what he had said, she was not especially surprised that he subsequently did so. Mrs A was mindful of her sister's anxiety, and did not pursue the matter at that time.

14. Mrs A recalls that they also discussed Voltaren, which Mrs B said she could not take due to inflammation of her stomach lining from anti-inflammatories she had taken for a bad back. Dr C talked about third generation non-steroidal anti-inflammatories, and

[5] Dr C provided services to the hospital in this case as a private medical practitioner. He is a member of a group of anaesthetists.

his intention to prescribe these intravenously postoperatively. Mrs A recalls that the rationale for this seemed reasonable.

15. On the "Anaesthetic Consent", signed by Mrs B, Dr C noted as the record of their discussion:

> "GA [General Anaesthetic] ETT [Endo-tracheal tube] See PH [past history]
>
> - airway shape
>
> K [Ketamine]
> PCA – NSAIDS"

16. There was a circle around the "PH", which, Dr C submitted in his response to HDC, was an indication that emphasis had been given to Mrs B's history.

17. In response to my provisional findings, Dr C notes that his written record in relation to consent was not an inclusive account of what Mrs B was consenting to, and that he would have made more expansive records about the analgesia discussions had he realised how contentious it would become.

18. Dr C notes that given the time that has elapsed since these events, he cannot recall specific details of his discussion with Mrs B. However, he refers to his usual practice. He states that he is certain he discussed the risks and benefits of morphine and codeine with Mrs B, and that he believes he would have explained why he considered that the benefits outweighed the risks. Mrs A does not recall an explanation of the benefits outweighing the risks. Dr C states that the "consequence" reaction of postoperative nausea and vomiting are the most common discussion content in this situation. He cannot recall whether it was his understanding at the time that Mrs B knew he was going to use morphine, but notes that this is not a basis for assuming the negative.

19. Dr C states that the patient wristband is a record of clinical alerts, and that the action taken following the identification of an alert depends on an assessment of the risk:benefit ratio of that action.

20. Dr C believes that he "had consent to direct management (and pain management in particular) according to 'what a usual patient in usual circumstance[s] will achieve by a balance between risk and benefit' (to paraphrase the Medical Council definition of reasonable consent processes)". He states further that he may have believed this consent was given after the detailed discussion of the non-steroidal anti-inflammatory drugs, and he "intuitively extended the concept to analgesic managements …"

21. Dr C explained that some aspects of consent are implicit, and submits that "the less harm is likely, the more implicit is acceptable". He notes other circumstances in which it would not be expected or usual for anaesthetists to seek consent for specific types of drugs or named drugs.

Surgery and postoperative care, 18 August 2009

22. At 10.50am, Mrs B proceeded to theatre and anaesthesia was induced. Surgery commenced at 11.13am and was completed just over an hour later.

23. At 12.25pm, Mrs B was transferred to the postoperative care unit (PACU). Postoperative analgesia was charted by Dr C:

Parecoxib	40mg	IV	once in PACU
pethidine	25mg	IV	PRN [as required]
cyclizine	25mg	IV	PRN if sick, maximum twice in PACU
ketamine	6mg	IV	PRN, boluses from infusion set up

24. He noted further instructions:

> "[A]nalgesia Paracoxib very early ([with or without] pethidine) and Ketamine […] bolus[6] 6mg prn @ 1 [to] 2 min intervals […] max 5 times limited only by sedation onset/increase".

25. A morphine PCA was charted (2mg dose).

26. The ketamine infusion was commenced at 12.30pm at a rate of 8mls per hour, with instructions to reduce this to 7mls per hour in four hours. Mrs B was given 100mg of pethidine between 12.35pm and 1.10pm, and 40mg of Parecoxib at 1pm.

27. A morphine PCA was commenced at 1.30pm and, at 1.45pm, Mrs B was returned to the ward.

28. Dr C charted regular and "as required" medications as below:

ketamine infusion review PRN see separate charting			
Codalgin	2 tabs	PO [orally]	4 hourly
max 10 tabs in 24 hrs			
cyclizine	12.5 mg	PO/IV	PRN
to a maximum of 50mg in 12 hours			
droperidol	1 mg	IV	PRN if sick to 8 hourly
with or instead of cyclizine			
Zofran	4mg	IV	8 hourly PRN as 3rd string antiemetic
Antiemetic permitted in combination depending on effectiveness			
Parecoxib	40mg	IV	daily (from time of PACU dose)
2 doses only			
Oxynorm	10mg	PO	To 4 hourly
Oxycontin	10mg	PO	BD [twice a day] (max)[7]
(maybe useful at night when oxynorm supply is infrequent)			

[6] A single, relatively large dose of a drug given to rapidly achieve the required therapeutic concentration in the bloodstream.

[7] Codalgin is a combination of paracetamol and codeine. Cyclizine, Zofran and Droperidol are used for nausea.

29. Mrs B's own usual medications, Losec and Betaloc, were noted as continuing.

30. At 4pm, Mrs B was given Codalgin, and at 4.30pm the ketamine infusion was reduced to 7mls per hour as per Dr C's instructions.

31. A student nurse noted at 11pm that Mrs B had been sleepy throughout the shift and that the ketamine infusion had been reduced to 5.8mls per hour on Dr C's instructions. The nurse noted that Mrs B was encouraged to decrease her PCA use as she had been feeling very "spaced out". A registered nurse (RN) subsequently added that Mrs B had been seen by Dr C at 6pm, and that:

> "I brought to his attention the feeling she has with morphine (spaced out) or codeine but he was not concerned. Said to ring him until 6am then [Dr D] after this time (he is away)."

32. Mrs B does not recall Dr C's visit at 6pm. The RN does not recall whether Dr C provided any further explanation or information at this time in relation to Mrs B's pain relief, but considers that if more specific information had been given, she would have documented this.

33. Overnight, Mrs B was given Codalgin every fours hours, one dose of cyclizine at 10pm and two doses at 1.15am, and Zofran at 2.15am.

34. At 10.45pm, the RN phoned Dr C as Mrs B had reported tingling, mainly in her right arm and slightly in her left arm. The RN noted that Dr C was not too concerned by this, but said that they should contact him during the night if necessary. She also recorded that Mrs B had not used the PCA since 7pm and had only had paracetamol.

35. The nurse looking after Mrs B overnight recorded that the tingling had subsided, but that Mrs B had not slept well. It was noted that she had complained of nausea and vomited once, and that because of the nausea, she was reluctant to use the PCA. She did not want Panadeine [Codalgin] because of the "spaced out" effect from codeine. She was given regular paracetamol.

Postoperative care, 19–23 August

36. At 8.30 the next morning, Mrs B was reviewed by the surgeon. It was noted that the ketamine infusion had been discontinued, and Codalgin recharted as Panadol. The nursing note at 2pm recorded that the PCA had also been discontinued, and that regular analgesia had been given with good effect.

37. Mrs A recalls that when she visited her sister that day, Mrs B's concerns were more about feeling spacey and nauseous, than pain.

38. At 10pm, it was noted that Mrs B had continued to complain of nausea, and Dr D was contacted. Dr D prescribed 0.5mg of droperidol and a Scopoderm patch,[8] which were used with good effect. Nursing notes record that Mrs B had refused Oxynorm and Oxycontin that afternoon, and that she only wanted paracetamol if possible.

[8] A topical patch also used to alleviate nausea.

39. The nurse on duty overnight noted that Mrs B's pain was well controlled with paracetamol only, that she had declined any other analgesia, and that oral cyclizine had been effective in controlling her nausea.

40. The following day (20 August), records show that at 3.30pm Mrs B rated her pain level as two out of ten at rest and four out of ten with activity.[9] Mrs A recalled that when she visited, her sister rated her pain as four at rest, and six when mobilising. Mrs A, an ex-nurse, considered that this was an unacceptable level of pain at this stage, and asked nursing staff whether her sister could be prescribed tramadol or pethidine.

41. A student nurse noted that she had left a message on Dr C's phone regarding the request for tramadol and pethidine. It was noted that Mrs B had had nausea throughout the shift, and that cyclizine had been given with minimal effect. She was given Zofran at 11am and then droperidol at 1.30pm, with good effect. Pethidine and tramadol were charted that afternoon by another doctor, and administered later that evening.

42. Progress notes that night show that Mrs B slept well between cares, with no complaints of pain or nausea.

43. Notes for 21 August indicate that Mrs B's nausea and vomiting were reducing, and that her pain was being controlled effectively with paracetamol. Her pain levels at 8am were one at rest and two with activity.

44. On 22 August, the surgeon noted that Mrs B was still a little sore but that she would probably go home the following day. Mrs B continued to have regular paracetamol, but there was an increase in her reported pain levels. At 9.30pm she reported pain as six out of ten at rest and with activity, and she was given a further dose of tramadol.

45. On 23 August, Mrs B was discharged home. She was given a prescription for tramadol.

Further information from Dr C

46. Prior to the start of this investigation, Dr C was asked to respond to Mrs B's complaint. HDC then sought preliminary advice from an independent expert, anaesthetist Dr Vaughan Laurenson. Dr Laurenson considered that Mrs B was entitled to a more adequate explanation from Dr C as to why he chose to use morphine and codeine. Dr C was invited to comment on this, and further advice was sought from Dr Laurenson.

47. The following points are noted from Dr C's responses to Mrs B's complaint, Dr Laurenson's advice, and my provisional opinion.

Rationale for medications prescribed

48. Dr C considers that his analgesia choices were reasonable and valid. He stated that in the case of Mrs B, the risk of poorly relieved pain was greater than the side-effects allegedly attributed to the drugs involved. He noted that Mrs B was not "allergic" to

[9] Where zero indicates no pain and ten indicates maximum pain.

morphine, and he does not consider that he prescribed this unnecessarily. He considers that the reaction she described is "so common (almost universal) it may be called a 'consequence'". Dr C stated that he considered the information provided by Mrs B in relation to morphine and codeine, and that in his view "neither the 'spaced out' feelings nor the postoperative vomiting were 'consequently' related to the drugs alone". He stated that some degree of dysphoria was always highly probable, noting also that she had had a similar experience with antihypertensive medication in the past.

49. In response to my provisional findings, Dr C stated that he does not consider Mrs B's requests not to have morphine were explicit or that he ignored her instructions. He stated: "I just DO NOT give patients drugs so explicitly excluded."

50. Dr C noted that with the PCA, Mrs B "had the opportunity to use, or not, the analgesia on the basis of her real time analgesic need". He stated further:

> "She always thus had the ability to balance, by her own actions, the 'risk' of side-effects, with her contemporaneously assessed benefit. Clearly when she did not apply the know[n] benefits (by declining the medication while the other available prescriptions were not applied) she and her sister were aware of the painful consequences."

51. In his preliminary advice, Dr Laurenson stated that Dr C could have prescribed analgesia other than morphine and codeine (see also Appendix 1, question 5). Dr Laurenson stated that possible alternatives included fentanyl, tramadol and pethidine, and noted that studies showed the overall incidence of side-effects, particularly nausea and vomiting, is similar for all of these drugs. However, as some patients who have problems with one opiate do not have problems with another, it can be worth trying an alternative, with the proviso that the patient is warned that the outcome may be no different.

52. In response, Dr C noted his reasons for considering that the alternatives suggested by Dr Laurenson were inadvisable. He stated that fentanyl is neither more nor less likely to produce the side-effect in question, and he is "less impressed that intuitive swapping of narcotics from one to another (hoping to change the side-effect profile without introducing others) is useful".

53. With regard to tramadol, Dr C stated:

> "Using tramadol and rationalising the then frequently given Odansteron antiemetic is advised to demonstrate a confusing and sometimes unpredictable conundrum of serotonin neurochemistry. I like to avoid that if possible, believing the analgesic effect is inadequate (early/soon) after laparotomy anyway, and certainly less so than multimodal use of the alternatives. Tramadol seems peculiarly emetogenic in females after abdominal surgery and is not popular in our [gynaecology] wards."

54. Dr C also explained his rationale for prescribing pethidine:

> "I did not chart her pethidine in deference to [Mrs B's] assertion that it was well tolerated. I did so as a pragmatic response to the almost irresistible preference that PACU nurses have to use it … for establishing 'transitional/initially durable' analgesia and to suppress shivering … despite its actual indifference in doing the former (in acceptable doses) and its well known initiation of early post op nausea and vomiting. My preferred option is also charted … IV ketamine which has a better evidence based application, but does not satisfy the PACU [nurses'] insurmountable preference to use pethidine."

55. In his response to my provisional findings, Dr C stated that using pethidine for the reasons outlined above was not, in his view, a compromise of professional standards, but a compromise "at a fairly low level".

56. Dr C noted that there are changes in medical care as new evidence emerges, and this can impose "stresses on established routines enshrined in historical practice". He stated that the effects of such stresses between staff is usually manageable and temporary, "despite the (sometimes) imperfections of the results".

57. He stated that while some of the nursing staff do not agree with the regimes prescribed, they are not responsible for the outcomes.

Changes to practice

58. Dr C stated that for patients with concerns about their analgesia he now directly and specifically asks about drugs to be excluded, is more pointed in his questioning, and focuses on the risks, benefits and options.

Other matters

59. In responding to this complaint, Dr C noted the failure of nursing staff to administer all postoperative medications in accordance with his instructions. Mrs B did not receive any analgesic boluses of ketamine in PACU, or the second dose of Parecoxib. The third choice of antiemetic, Zofran, was used ahead of the second choice, droperidol. Dr C also stated that Oxynorm and Oxycontin were prescribed but not adequately used.

60. Dr C also commented on the fact that nursing staff attempted to contact him on 20 August, in spite of an earlier note in the nursing records making it clear that he was available until 6am on 19 August, and that arrangements had been made for another anaesthetist to provide cover after this time.

Further information from the hospital

61. In light of the issues raised in relation to the nursing care provided to Mrs B, further information and comment was sought from the hospital.

Administration of prescribed medication

62. The Chief Operating Officer advised that in view of these events, adherence to Dr C's prescribed regimes was discussed with the relevant nursing team. The hospital's Pain Nurse Specialist and the Clinical Pharmacist were asked to provide in-service training to the nursing teams, to reinforce medication policies in relation to Dr C's prescriptions.

63. It was also noted that Mrs B chose to decline some of the medication prescribed, and that nurses felt they were respecting her right to choose in this episode of care, and adhering to the Code of Rights. Codalgin was not given to Mrs B because of her request not to have medications containing codeine. She was instead given paracetamol and the prescription was altered the next morning by the surgeon.

64. The Chief Operating Officer also noted the professional responsibilities of nursing staff to act as patient advocates, to question decisions that they perceive as being inconsistent with the patient's best interests, and to escalate matters of concern. He noted the difficulty for nurses if a specialist is not receptive to listening to, nor taking these concerns into account. He stated that while this is not an excuse for not escalating concerns or adhering to prescribed regimes, it may provide an explanation.

65. The nurse who administered the third choice of antiemetic ahead of the second choice made an error. This was addressed directly with her, and was also to be covered in the in-service sessions.

Contacting specialists

66. The Chief Operating Officer confirmed that the hospital has a system in place to ensure staff are informed when a specialist is on leave and cover is being provided by a colleague. This information is recorded in the patient notes and displayed in the area where calls to medical staff are made. It was noted that given these events, the hospital would investigate other options for ensuring this information was communicated as required.

Pethidine in PACU

67. The Chief Operating Officer stated that PACU staff do not have a preference for using pethidine. He noted that nursing staff have a "professional responsibility to make suggestions regarding the care of patients given their knowledge of patient history, reaction, and general progress. They do this and may suggest the use of pethidine or other medications using their judgement."

Initiation of changes

68. The Chief Operating Officer outlined the systems in place at the hospital to ensure nursing staff are aware of, and able to give effect to, innovations and significant changes to practice in relation to anaesthesia. He notes that in general, "[The hospital] staff have extremely good communication with specialists, allowing open, professional discussion to ensure that patients receive the best possible care".

Opinion: Breach — Dr C

Introduction

69. Under Right 7 of the Code, consumers have the right to make an informed choice and given informed consent for medical treatment.[10] Right 6(2) of the Code recognises

[10] See footnote 4.

that for this to occur, consumers have the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.[11]

70. When Mrs B completed the "Patient Registration Form" and "Anaesthesia Assessment — Patient Questionnaire" on 13 August 2009, she wrote codeine and cloth sticking plasters, indicating allergies or sensitivities to these. She did not write morphine, but did record that she had previously had postoperative vomiting and nausea. Prior to surgery on 18 August, she told nursing staff that she had previously vomited after having morphine, and this was documented on the preoperative nursing assessment. Allergy stickers were placed on several pages of the clinical notes, with the information about Mrs B's reactions to morphine, codeine and sticking plasters. Alerts were written on her patient wristband. Mrs B also spoke with Dr C during the pre-anaesthetic consultation later than morning, about her concerns regarding morphine and codeine.

71. It is evident that Dr C was fully aware of the alerts in Mrs B's notes, and of Mrs B's views on morphine and codeine. The questions are whether, in light of this, Mrs B was provided with sufficient information about what Dr C intended and the choices available to her. Accordingly, the further question is whether Dr C had her consent to prescribe morphine and codeine postoperatively.

Acceptable practice

72. Mrs B was not allergic to morphine or codeine. She did not say she was allergic to these, and allergy stickers are used to record other clinical alerts. However, Mrs B told nursing staff and Dr C what had happened previously when she had had codeine and morphine. On the basis of her experience, she understood that morphine had caused her to vomit postoperatively, and codeine caused her to feel "spaced out". Accordingly, she asked not to be given these. Mrs B recalls stating clearly that she did not want morphine, although Dr C considers this to be an overstatement. I am satisfied on the basis of the information gathered, that Mrs B made it clear to Dr C that she did not want morphine or codeine.

73. In any situation involving a patient undergoing anaesthesia, there may be several approaches or regimes that fall within the realm of acceptable practice. Dr C clearly considered that despite the information provided by Mrs B, the benefits of morphine and codeine as postoperative analgesics outweighed the risks. I accept Dr Laurenson's advice that there were satisfactory alternatives. Dr Laurenson states that tramadol, pethidine and fentanyl were possibilities, and it is noted that Mrs B told Dr C that she had previously had two of these, tramadol and pethidine, without problems. Once Mrs B had raised her concern that she did not want to be administered morphine or codeine and that she had previously used tramadol and pethidine without problems, if Dr C did not consider that they were reasonable options, he should have clearly explained this and his reasons to Mrs B. If he considered that they were possible but less advisable, the relative risks and benefits should have been explained to Mrs B, so that she could decide for herself.

[11] See footnote 3.

Adequacy of information provided

74. On the basis of the information provided by Mrs B, Mrs A and Dr C, I do not consider that Dr C gave Mrs B sufficient information. As a result she was unable to consider the choices available to her, such as refusing to have Dr C provide her anaesthetic treatment.

75. From the information Dr C has provided, it appears that he considered that the alternatives to morphine and codeine were inferior to the point that they did not constitute acceptable options. If this is so, he did not effectively communicate this to Mrs B.

76. As noted in a previous investigation in relation to the provision of information by an anaesthetist, "Right 6 of the Code recognises that the information a patient might need is not confined to the risks of the treatment option being recommended by the provider."[12] Patients are entitled to information about all relevant treatment options. This includes clinically appropriate alternatives raised by the patient which the clinician does not favour.

77. It is not for me to comment on whether morphine and codeine were more or less likely to cause the postoperative side-effects, or consequences, that Mrs B was concerned about. As Dr Laurenson states, in discussing the risks and benefits of alternatives it would still have been necessary to advise Mrs B that not using morphine and codeine did not guarantee she would not experience those same side-effects. Mrs B was not asking for a guarantee; she was asking not to be given morphine or codeine.

78. Dr C considers that neither the "spaced out" feelings nor the postoperative vomiting were caused by the drugs alone. Again, it is not my role to determine the extent to which the morphine and codeine caused Mrs B to feel the way she did. That is not the point. I accept that if, despite a clear recommendation from Dr C, Mrs B had opted for different clinically indicated analgesia, her postoperative course may have been similar or indeed, even worse.

79. My other concern about the information Dr C provided preoperatively was the lack of clarity at the outcome of the discussion in relation to morphine. Mrs B acknowledges that her recall of the consultation is limited, as she was very anxious at the time. Mrs A recalls the consultation more clearly. Her impression at the end of the conversation was that Dr C may have intended to use morphine in spite of Mrs B's reservations and request, although she does not recall whether he said this explicitly. Dr C cannot recall his impression at the time, but notes that no assumptions should be made on this basis. Morphine was not specified on the consent form. It appears to me that Mrs B may well have been left not knowing whether he was going to prescribe morphine, and at the very least, Dr C acknowledges this possibility.

[12] http://www.hdc.org.nz/decisions--case-notes/commissioner's-decisions/2006/05hdc07699 p 25.

Consent

80. Dr C states that some aspects of consent are implicit, and that he may have "intuitively extended the concept" following the discussion of non-steroidal anti-inflammatory drugs. Dr Laurenson concurs that some aspects of consent are implicit, but notes that in light of Mrs B's concerns about codeine and morphine, this aspect of her treatment should have been discussed rather than taken as implicit. I agree with Dr Laurenson.

81. The process of obtaining consent does not require that a patient is provided with specific details about every aspect of the proposed treatment and related medications. As Dr Laurenson states:

> "It is unrealistic to expect a lay person to have the academic and emotional ability to cope with a detailed explanation of all aspects of anaesthesia and anaesthesia related drugs in a consultation held in the morning before major surgery."

82. However, I agree with Dr Laurenson that it is important to address any specific concerns, fears, or misunderstandings that the patient may have about the anaesthesia. This is reflected in the Australian and New Zealand College of Anaesthetists "Recommendations for the Pre-anaesthesia Consultation" (2008) (ANZCA Recommendations), with the recommendation that the pre-anaesthesia consultation includes "[a] discussion with the patient (and/or guardian) of those details of the anaesthetic management which are of significance to the patient".[13]

83. Dr Laurenson states further that while Dr C undertook the consent process and covered appropriate topics, "it is very unlikely that he had an appropriate discussion about the details of anaesthetic management of significance to the patient, in this case the use of morphine and codeine".

84. It is noted that the only drug specified in Dr C's written record of the consent discussion is ketamine. The other topics covered are referred to in broad terms: general anaesthetic, endotracheal tube, non-steroidal anti-inflammatory drugs, and the PCA. Dr C's decision not to specify the drug he had chosen for the PCA is particularly significant, given that this was discussed and Mrs B had expressed a clear preference, if not a request, to not have morphine.

85. Dr C notes that Mrs B signed the consent form, which states that the patient has had adequate opportunity to ask questions about the anaesthetic and the possible risks, and received all of the information required. Patients facing surgery are vulnerable and often scared, and it is essential that health professionals are mindful of this. As Bond states in *Cole's Medical Practice in New Zealand 2009*:

> "Informed consent is more than getting a patient to sign a consent form. It is a two way communication process which results in the patient feeling confident that

[13] Australian and New Zealand College of Anaesthetists "Recommendations for the Pre-anaesthesia Consultation" (2008), paragraph 3.5.

> they have enough information to agree to undergo a specific medical intervention."[14]

A signed consent form is not, in itself, sufficient evidence that consent has been obtained appropriately.

86. I note also that the consent process was undertaken by Dr C on the morning of Mrs B's surgery. The exact time is not documented, but as Mrs B was admitted at 8.30am and surgery commenced at 10.50am, the discussion took place less than three hours before surgery. It is recognised in the ANZCA Recommendations that there are inherent difficulties in adequately assessing patients admitted on the day of surgery.[15] It is noted that there are circumstances in which early consultation is not possible. However, in Mrs B's case, while events had unfolded rapidly it was not emergency surgery. Mrs B acknowledges that she was stressed and anxious, and she has limited recall of the information that was provided to her. The ANZCA Recommendations also note that it is particularly important for the consultation to take place at an appropriate time prior to anaesthesia and the planned procedure where there is significant patient co-morbidity, *where major surgery is planned*, and *where there are specific anaesthesia concerns* (my italics).[16] The issue of allowing patients adequate time to reflect on information provided to them prior to surgery has also been highlighted in previous investigations.[17]

Documentation

87. Dr C's documentation in relation to consent was not helpful. The ANZCA Recommendations regarding documentation state that the pre-anaesthesia consultation should include "[c]ontemporaneous written notes documenting the consultation and informed consent which should become part of the medical record of the patient".[18]

88. The importance of the medical record was highlighted by former Commissioner Ron Paterson:

> "It is often stated by medical defence lawyers: 'If it isn't documented, it didn't happen.' Baragwanath J made comments to similar effect in his decision in *Patient A v Nelson-Marlborough District Health Board.*[19] Judge Baragwanath noted that it is through the medical record that doctors have the power to produce definitive proof of a particular matter (in that case, that a patient had been specifically informed of a particular risk by a doctor). Doctors whose

[14] Bond, B, "Informed Consent". In: St George, I (ed), *Cole's Medical Practice in New Zealand 2009* (Wellington: Medical Council of New Zealand, 2008), p 86.
[15] Australian and New Zealand College of Anaesthetists "Recommendations for the Pre-anaesthesia Consultation" (2008), paragraph 2.5.
[16] Australian and New Zealand College of Anaesthetists "Recommendations for the Pre-anaesthesia Consultation" (2008), paragraph 2.4.
[17] http://www.hdc.org.nz/decisions--case-notes/commissioner's-decisions/2006/05hdc07699
http://www.hdc.org.nz/decisions--case-notes/commissioner's-decisions/2009/08hdc20258
[18] Australian and New Zealand College of Anaesthetists "Recommendations for the Pre-anaesthesia Consultation" (2008), paragraph 3.8.
[19] *Patient A v Nelson-Marlborough District Health Board (HC BLE CIV-2003-204-14, 15 March 2005).*

> evidence is based solely on their subsequent recollections (in the absence of written records offering definitive proof) may find their evidence discounted."[20]

89. The cryptic notes written by Dr C on the consent form — "GA ETT see PH [circled] airway shape K PCA-NSAIDS (Cx3)" — would not have enabled Mrs B to be clear about what she had consented to, and thereby further compromised her ability to give informed consent.

90. In the aforementioned investigation regarding the provision of anaesthetic information, anaesthetist Dr David Chamley, in his capacity as an expert advisor for ACC, noted the importance of documentation when there are issues of a contentious nature. That case involved the administration of morphine to a patient with a documented allergy, but where the anaesthetist believed the patient had previously experienced side-effects rather than an allergic reaction. While this is different from Mrs B's situation, in that it was never suggested she was allergic to morphine, Dr Chamley's point remains relevant. He stated: "Given that [the doctor] intended to give a drug which he was aware that [the patient] did not want, then regardless of the validity or otherwise of his views re the allergy, the discussion re this should have been documented."[21]

91. This matter is noted also in the ANZCA "Guidelines on Consent for Anaesthesia or Sedation" (2005):

> "The extent of documentation may be dictated by local legislation and practice but it is wise to record significant details of the consent as part of the patient's notes, including reference to the discussion of relevant material risks and the agreement by the patient to undergo the treatment."

92. In Mrs B's situation too, it would have been prudent for Dr C to have documented more fully his discussion in relation to the PCA and morphine use. As it is, the consent form does little to support Dr C's position that he had Mrs B's consent to prescribe morphine.

93. However, I note that ANZCA defines its guidelines as documents "offering advice", and that the Consent guideline refers to such documentation as being "wise", rather than a requirement.

Communication and co-operation with nursing staff

94. There are several aspects of the care provided to Mrs B and the information provided to HDC in the course of this investigation which suggest that communication between Dr C and nursing staff could have been better.

95. Dr Laurenson states that he finds Dr C's rationale for charting pethidine "professionally difficult". Dr C suggests that he charted pethidine not in deference to Mrs B's assertion that it was well tolerated, but as a pragmatic response to the

[20] http://www.hdc.org.nz/decisions--case-notes/commissioner's-decisions/2006/05hdc07699 pp 29–30.
[21] http://www.hdc.org.nz/decisions--case-notes/commissioner's-decisions/2006/05hdc07699 p 29.

preference of PACU nurses, even though he does not appear to consider the reasons for their preference are valid.

96. It is somewhat difficult to reconcile this with Dr C's comment that while some nursing staff do not agree with prescribed regimes, they are not responsible for the outcomes. I agree with Dr Laurenson that it is good that Dr C considers the needs and wishes of other members of the team, but I would be concerned if this were his primary consideration and took priority over his clinical judgement. I have noted Dr C's further comment that he does not consider the use of pethidine for the reasons he states to be a compromise of professional standards.

97. When Dr C reviewed Mrs B at 6pm on the day of surgery, the nurse drew Dr C's attention to morphine and codeine issues, and noted that he was not concerned. Dr C decreased the rate of the ketamine infusion, which Dr Laurenson states was "probably appropriate", as hallucinations and the "spaced out" feeling are side-effects of ketamine. It is not known whether Dr C told Mrs B this, as she does not recall his visit at all. There is no evidence that this was explained to nursing staff, who continued to note that Mrs B was reluctant to use the PCA and declined codeine, because of the side-effects. It appears that Mrs B, and possibly nursing staff, continued to attribute her symptoms to the morphine. Mrs B refused to use the pain relief that was available, which may have resulted in her experiencing increased pain.

98. I agree that nursing staff have an advocacy role, and that they need to address matters that they consider may not be in a patient's best interests. This can be difficult to do, for a number of reasons. However, Dr C is right to be concerned when his prescribed medication regime is not followed by nursing staff. He should be able to have confidence that nurses act in accordance with postoperative instructions, and in the event that this is not possible (for instance, if the patient declines a prescribed medication) that the matter is followed up appropriately, including contacting the relevant specialist if required. Nursing staff should also contact the relevant specialist if they have specific concerns about administering a prescribed medication.

99. I note that the hospital has undertaken further education and training with nursing staff in relation to their adherence to medication policies.

100. As Dr C notes, medical care changes in response to the evidence-base, and the initiation of these changes challenges established routines. Accordingly, doctors have a responsibility to contribute to the education of other members of the team in relation to these changes. I note the arrangements in place at the hospital with regard to communicating and implementing changes to practice, but in my view, it would be appropriate for Dr C to consider whether he can do anything further to ensure relevant information is shared effectively with nursing staff.

101. While I do not consider that these matters warrant a finding that the Code was breached in relation to communication between providers, they do suggest that the relationship between Dr C and nursing staff was not optimal.

Summary

102. For the purposes of Right 6(2) of the Code, the question is whether Mrs B was given sufficient information by Dr C to make an informed choice. In my view, Dr C did not provide Mrs B with adequate information about the medication he intended to administer for postoperative pain relief or why he did not intend to administer the medication she preferred.

103. Given that postoperative pain relief, in particular morphine and codeine, was clearly an issue of significance for Mrs B, I consider that this was a matter that Dr C needed to discuss explicitly, clearly, and fully. Furthermore, it should have been clearly documented. In my opinion this did not occur and, as such, I do not consider Dr C acted appropriately to obtain Mrs B's informed consent for the treatment he provided.

104. Dr Laurenson states that in his view, Dr C's departure from expected standards was at the lower end of severity, on the basis that his treatment decisions were safe. While I accept that Dr C's decisions to prescribe morphine and codeine did not put Mrs B at risk of harm, I consider that Dr C disregarded her views and wishes to the extent that a breach finding is warranted.

105. In these circumstances, I find that Dr C breached Rights 6(2) and 7(1) of the Code.

Other matters — Nursing care

106. In relation to the concerns raised in the course of HDC's enquiries with regard to the nursing care provided to Mrs B, I am satisfied that the hospital has reflected on these and given due consideration to how it might improve its service. I do not consider the care provided by nursing staff warrants formal investigation by this Office.

Recommendation

107. I recommend that Dr C:

- provide to HDC by **29 April 2011** a written apology for forwarding to Mrs B.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Australian and New Zealand College of Anaesthetists and the District Health Board, and they will be advised of Dr C's name.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix 1 — Independent advice to Commissioner

As noted previously, Dr C was asked to respond to Mrs B's complaint prior to the start of this investigation. HDC then sought preliminary advice from an independent expert, anaesthetist Dr Vaughan Laurenson. Dr Laurenson considered that Mrs B was entitled to a more adequate explanation from Dr C as to why he chose to use morphine and codeine. Dr C was invited to comment on this, and further advice was sought from Dr Laurenson.

The following advice was provided by Dr Laurenson following the start of the investigation.

> "I have been asked by the Commissioner to provide an opinion on case number C09HDC01691 regarding [Mrs B]. I have read and agree to follow the Commissioner's guidelines for independent advisors.
>
> I am a specialist anaesthetist in active clinical practice in a major metropolitan centre. I qualified MBChB 1972, FFARACS 1981, and FANZCA 1992. My clinical practice includes regular gynaecological surgical lists.
>
> I have been asked to provide advice on the following questions:
> *[Deleted for brevity — questions included in advice below]*
>
> I have received copies of the following documents which I have read. I have based my opinion on the information provided by these documents.
>
> 1. Letter of complaint from [Mrs B].
> 2. Letter of complaint from [Mrs A] RN, sister of [Mrs B].
> 3. [Mrs B's] notes from [the hospital], including additional information received in May 2010.
> 4. Responses to the complaint by [Dr C] anaesthetist, dated 16/10/09, 12/12/09, 8/6/10 and an email dated 23/6/10.
> 5. Letter of notification dated 4th May 2010.
> 6. Correspondence between HDC and [the hospital].
>
> Summary of events
> *[Deleted for brevity]*
>
> **My opinion on the matters requested by the Commissioner**
>
> 1. Please comment generally on the standard of care provided to [Mrs B] by [Dr C].
>
> I have assessed standard of care by reviewing the process that took place.
>
> A pre-anaesthetic consultation occurred and included a discussion of the anaesthetic and postoperative management plan. However the role of morphine

and codeine in the postoperative analgesia does not appear to have been discussed (see below).

The general anaesthetic is well-documented. [Dr C] apparently chose to use remifentanil infusion (a short-acting opiate), without any longer acting opiate, to supplement the volatile anaesthetic agent used to maintain anaesthesia.

In the recovery ward the postoperative pain relief plan of ketamine infusion supplemented initially with pethidine and then with morphine was initiated.

[Dr C] visited [Mrs B] on the ward that evening (1800hrs). At this stage she was feeling very 'spaced out'. The nurse discussed with [Dr C] that she felt this may be due to the morphine PCA. [Dr C's] response was to reduce the rate of the ketamine infusion. This was probably appropriate as hallucinations and a feeling of being 'spaced out' are side-effects of ketamine. However this does not appear to have been explained to the nurse or the patient. [Mrs B] interpreted the 'spaced out' sensation and the subsequent vomiting as side-effects of the morphine PCA and stopped using it.

[Dr C] was contacted later in the evening (2245hrs) about a matter unrelated to this report. He had notified the staff that he would be away the next day and notified the nurses who would be providing cover for him.

It is my opinion that with the exception of the choice to use morphine for postoperative analgesia, and the management of side-effects of the chosen postoperative analgesia, standards of care provided by [Dr C] appear to be appropriate.

2. Please comment on the adequacy of the steps taken by [Dr C] to obtain consent for anaesthesia, in particular consent to administer morphine and codeine.

A pre-anaesthetic consultation took place in the morning before the surgery. From the notes on the consent for anaesthesia form which was signed by both [Mrs B] and [Dr C], there was a discussion of general anaesthesia with an endotracheal tube. A plan for postoperative pain management in the form of ketamine, patient controlled analgesia (PCA), and nonsteroidal anti-inflammatory drugs was discussed. There is no record of what drug was planned for the PCA, or any reference to codeine.

It is my opinion that the process of obtaining consent was followed out and appropriate subjects were discussed but given [Mrs B's] documented adverse reaction to both these drugs it is highly unlikely that she would have consented to their administration.

3. If not included above, did [Dr C's] consent process comply with the relevant standards? If not please explain.

The most appropriate document to use when judging relevant standards for pre-anaesthetic consultation is the Australian and New Zealand College of Anaesthetists Recommendations for the pre-anaesthetic consultation. It should be noted that this document is intended as a guide to Fellows of the college. [Dr C] is [overseas] trained, but has been in practice in New Zealand with vocational registration since 1976, and as such could be expected to be aware of standards expected of a vocationally trained anaesthetist in New Zealand. These guidelines include:

Para 3.5) 'A discussion with the patient of those details of the anaesthetic management which are of significance to the patient.'

And (para 3.6) about informed consent: 'this should include consent regarding the type of anaesthesia, any invasive procedures pain management and other medication plan'.

My opinion is that while [Dr C] clearly went through the correct process and covered appropriate topics, I think it is very unlikely that he had an appropriate discussion about the details of anaesthetic management of significance to the patient, in this case use of morphine and codeine.

4. If not included above, please comment on [Dr C's] explanation of a reasonable consent process and implicit consent.

[Dr C] is correct in that some aspects of consent are implicit. As discussed above the important thing is to discuss details of anaesthetic management which have significance to the patient. It is unrealistic to expect a lay person to have the academic and emotional ability to cope with a detailed explanation of all aspects of anaesthesia and anaesthesia related drugs in a consultation held in the morning before major surgery. However it is important to address any specific concerns, fears, or misunderstandings that the patient may have about the anaesthetic that they are about to have. In [Mrs B's] case the documents provided would strongly suggest she had concerns about codeine and morphine and that these should have been discussed rather than taken as implicit.

5. Were there alternatives to morphine and codeine that could reasonably have been prescribed?

Morphine is a strong opiate, or pain relieving drug. There are a number of suitable alternatives in the same class of drug which could have been used. These include fentanyl, pethidine, and tramadol. As a group all these drugs have similar side-effects and efficacy (Acute Pain Management: Scientific evidence. 3 Ed.). However individual patients may experience different side-effects with the different drugs. This is significant because [Mrs B] informed [Dr C] that while morphine makes her vomit, she had previously successfully had pethidine and tramadol without adverse effects.

In my opinion there were suitable alternatives to morphine and codeine that could have reasonably been prescribed.

6. Please comment on [Dr C's] rationale for charting pethidine.

In my initial response to the Commissioner I have suggested that, the fact that [Dr C] prescribed pethidine for use in the recovery ward indicated that he was aware of [Mrs B's] desire to avoid morphine. [Dr C] responded that the reason he charted the pethidine was:

'I did not chart her pethidine in deference to [Mrs B's] assertion that it was well tolerated. I did so as a pragmatic response to the almost irresistible preference that the PACU nurses have to use it ... for establishing "transitional/initially durable" analgesia and to suppress shivering despite its actual indifference in doing the former (in acceptable doses) and its well-known initiation of early postoperative nausea and vomiting.'

I find this response professionally difficult. If I understand him correctly [Dr C] is saying that the only reason he charted pethidine was because the recovery nurses insist on it. While it is good that he is taking the needs and wishes of other members of the team into consideration, I do not think that this is a total explanation. There would be a number of opiates that would have been available to provide initial durable analgesia. While the patient is still recovering from anaesthesia it is unreasonable to expect them to achieve satisfactory blood levels of opiate drugs using a PCA and it is normal for the recovery nurses to give bolus doses of opiates initially. The drug to be used for this post operative pain relief needs to be charted by the anaesthetist. [Dr C] could have chosen to use fentanyl or morphine for this purpose if he did not believe that pethidine was going to be effective. Although [Mrs B] did not want morphine he had charted it (in the form of PCA) to follow the pethidine.

I find [Dr C's] logic for charting pethidine, when he did not plan to continue using it in the PCA, difficult to understand.

7. Are there any other aspects of the care provided by [Dr C] that you consider warrant additional comment?

In my early advice to the Commissioner I commented on several matters related to the nursing care for [Mrs B] namely:

1. What in-service education had taken place for the nurses who are expected to act appropriately to the postoperative orders written by [Dr C], which were, by his own admission 'initiation of changes'.

2. Why did the nurses fail to administer medications that were ordered and appropriate for [Mrs B]?

[Dr C] had implied that the hospital was investigating at least some of these matters. I note that [the hospital] has now responded to the Commissioner. The hospital was not aware of the problem and was not investigating it. I am pleased to see that the hospital has now initiated further education for the nurses to deal with [Dr C's] approach to postoperative analgesia. The second question referred to the failure to administer the oxycodone (oxynorm) that was charted. Despite the similarity of the name this drug is not codeine, and may have helped the pain. However it is an opiate and may have produced nausea and vomiting on its own. Hopefully further education will improve knowledge of this drug.

Oxycontin (a sustained release preparation of oxycodone) was also charted. The nurses were correct not to give this as it is contraindicated in the peri-operative period.

The response from the [hospital] reinforces my opinion that [Dr C] initiated changes to the postoperative management without suitable education of the other members of the team to ensure that the orders were appropriately carried out.

It is my opinion that [Dr C] did not provide an appropriate standard of care to [Mrs B]. I am required to indicate the severity of the departure from the expected standard. It is my opinion that his peers would regard this at the lower end of severity. I base this opinion on my assessment that although [Mrs B] obviously had an unpleasant time as a result of [Dr C's] management decisions, the treatment [Mrs B] received appeared to be safe.

Yours sincerely,

Vaughan Laurenson"