Care provided by orthopaedic surgeon following surgery
15HDC00312, 13 June 2017

Orthopaedic surgeon ~ Discectomy ~ Back pain ~ Information ~ Informed consent ~ Rights 4(1), 6(2), 7(1)

An orthopaedic surgeon performed a discectomy to alleviate a woman's back pain. During surgery, the surgeon found a large amount of scar tissue and despite using the appropriate clinical measure to identify the correct level of the spine to operate on, performed the surgery on the incorrect level.

An MRI report completed after the surgery indicated this had not been performed on the correct level, and the woman had ongoing symptoms. Despite this, the surgeon did not seek further advice from colleagues or the radiologist about interpretation of the MRI. The surgeon did not advise the woman that the MRI indicated it was possible he had operated on the incorrect level of her spine and did not explain that the steroid injections he proposed were in order to check whether this was the case. He did not inform the woman of this at the time because he wanted to confirm the situation clinically first.

Findings summary
It was held that the surgeon took appropriate clinical measures prior to surgery to identify the appropriate spinal level on which to operate. However, it was clear from the relevant MRI scan that decompression of the correct level had not been performed. In the circumstances, including ongoing symptoms, the surgeon is criticised for not seeking further advice from colleagues and/or the radiologist about the interpretation of the scan at that stage. By failing to do so, the surgeon did not provide services to the woman with reasonable care and skill and, breached Right 4(1).

The surgeon failed to advise the woman that the MRI report indicated that it was possible that he had operated on the wrong level of her spine, and that he intended to use the steroid injections to seek clarification in this regard. Accordingly, the surgeon breached Right 6(2). The woman was unable to make an informed choice or give informed consent to receipt of the steroid injections. It followed, therefore, that the surgeon also breached Right 7(1).

Adverse comment was made about the DHB not arranging a six-week follow-up appointment after the epidural steroid injections.

Recommendations summary
It was recommended the surgeon consult with orthopaedic peers and consider adding additional screening to his clinical regimen, undertake a review of his process for providing consumers with information during the surgical consent process and postoperatively, and apologise to the woman.