Orthopaedic Surgeon/Surgical Centre

Opinion - Case 99HDC07599/JS

Complaint

The Commissioner received a complaint from the consumer about the treatment she received from the provider at a surgical centre. The complaint was that:

- *In June 1998 the consumer had an operation to replace the ACL joint in her right knee performed by the provider.*
- *The consumer was discharged from hospital without medical advice or painkillers, only an appointment to see the provider in a few weeks. The consumer says she suffered pain after the operation and was not able to contact the provider during the weekend when the pain became unbearable.*
- *The consumer went to physiotherapy every day, did her exercises every day and went to the gymnasium to rehabilitate her knee. On the advice of her physiotherapist, the consumer told the provider about her pain. The provider replied that the pain was in her head. The provider's secretary stated "it's not our problem she doesn't do her exercises".*
- *The provider suggested the consumer obtain a second opinion, which she did. That orthopaedic surgeon arranged for an MRI scan and an arthroscopy. On 17 June 1999 he performed an ACL repair operation. The consumer says her knee already feels better in comparison.*

Investigation Process

The Commissioner received the complaint on 7 July 1999 and an investigation was commenced on 20 October 1999. Information was received from:

The consumer
The provider, an orthopaedic surgeon
The manager of the surgical centre
The physiotherapist

Relevant clinical records were obtained and viewed. The Commissioner obtained advice from an independent orthopaedic surgeon.

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Information Gathered During Investigation

The consumer suffered a right knee injury in May 1998. Her physiotherapist referred her to a general practitioner. The referral note stated:

> "*Thank you for seeing this 26 year old* [sportsperson] *who sustained a right knee injury ... about three weeks ago. She is keen to make the best possible recovery and return to competition. She has recently moved to* [city] *from* [city] *and is looking for a GP so, of course, I recommended you.*
>
> *Clinically she has a grade II rupture right MCL* [medial collateral ligament] *and grade I ACL* [anterior cruciate ligament] *rupture and positive medial meniscus tear.*
>
> *I would be grateful if you could arrange a referral to* [the provider] *as* [the consumer] *will require an ACL reconstruction.*"

The general practitioner wrote to the provider, an orthopaedic surgeon, on 11 June 1998. The referral letter stated:

> "*Thank you for seeing* [the consumer] *... who requires ACL and MCL repair – see letter from physiotherapist. She is a professional* [sportsperson] *and needs to be as perfect as possible.*"

The consumer consulted the provider on 16 June 1998. The provider wrote to the general practitioner following the consultation and advised:

> "*Thank you for your note concerning* [the consumer], *whom I met today regarding her injured right knee.*

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Despite her history of injury, which is very suggestive of ACL rupture – I did not find her knee to have marked anterior laxity, and I suspect that the ACL rupture may only be partial. This would also account for her knee flexion contracture – which is often seen following a partial rupture. However, it is also possible that she has a displaced medial meniscal tear – she certainly has medial-sided pain and joint line tenderness. There is no significant laxity now evident in the medial collateral ligament. X-rays of the knee are normal.

In discussion with the consumer], *we have agreed to go ahead with an EUA* [examination under anaesthetic] *and arthroscopic examination of the knee. Should it be evident that the anterior cruciate ligament is non-functional, I will proceed to an arthroscopic ACL reconstruction. I have asked* [the consumer] *to be in touch with us as soon as her ACC approval comes through and we will get her surgery done as soon as possible.*"

The provider performed the consumer's arthroscopic anterior cruciate ligament (ACL) reconstruction at 7.40am on 30 June 1998 under an ACC contract at the surgical centre.

The surgical centre's clinical notes recorded the provider's admission instructions, dated 30 June 1998, as follows:

"*(R) ACL GA* [general anaesthetic] – [name of anaesthetist]
Post Op: Elevate - pillows. IV fluids. Antibiotics. Analgesia. Up this pm with physio. Change dressing. Drains out. Discharge after physio tomorrow morning. See [private clinic] *in ten days.*"

The operation note dated 30 June 1998 recorded that there was no fluid in the joint, that collateral ligaments were intact and that there was evidence of an anterior cruciate ligament injury. At arthroscopy the joint surfaces of the patella and medial and lateral joint compartments were reported as normal but there was a rupture of the anterior cruciate ligament. An ACL reconstruction was carried out, using the middle third of the patellar ligament.

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The provider's discharge instructions were repeated on the operation note.

The provider wrote to the general practitioner after the surgery and advised:

> "*I did an arthroscopic ACL reconstruction on* [the consumer's] *right knee today. She had no joint surface or meniscal damage. At the completion of the procedure, her knee was stable to Lachman and anterior draw testing, and I would anticipate her having a good result from this procedure. She will start her physiotherapy rehabilitation programme with* [the physiotherapist] *later this week, and I will be seeing her again in ten days' time.*"

The consumer was returned to the ward at 10.45am. The surgical centre's nursing notes recorded that the consumer was seen by the provider on the afternoon of 30 June 1998.

The consumer received 75mg of pethidine and maxalon 10mg IV (for nausea) at 12.15 pm, panadeine x 3 at 1.30pm and 6.00pm, pethidine 75mg at 7.30pm, pethidine 75mg and maxalon 10mg IV at 9.30pm and panadeine x 3 at 10.00pm.

The consumer received panadeine x 3 at 2.00am and 6.30am on 1 July 1998. She felt nauseated at 6.45am and was given a maxalon suppository. She was given stemetil 12.5mg and a scopadem patch (both for nausea) at 8.15am. The consumer was seen by the provider during that morning, a physiotherapist at 2.00pm and discharged home at 3.00pm, without pain medication.

The consumer advised the Commissioner that she only remembered seeing the provider once after the surgery and was still "*very groggy*" so did not remember any conversation with him.

The provider advised the Commissoner that he did not recall the consumer being in excessive pain during either of his visits. He said that if pain management had been an issue the nurses at the surgical centre would have raised it either with him or, more likely, with the anaesthetist. The provider stated that the pain medication received by the consumer on 30 June and 1 July 1998 was not unusual and within the upper normal range for this type of surgery.

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Information Gathered During Investigation *continued*

The provider advised the Commissioner that the anaesthetist usually charts the medication to be supplied on discharge but that, "*due to an oversight*" by him, this did not happen. The provider stated:

> "*I have enquired of the* [surgical centre] *staff as to why, despite indication being made on the consumer's admission sheet that she would require post operative medication, this was not cross-checked by the nursing staff on discharge. Apparently this was overlooked ....*"

The Manager of the surgical centre advised the Commissioner:

> "*Patient was not given meds to take home.*
>
> *a)* [The anaesthetist] *had not charted same, possibly with concerns re nausea, this was missed by nursing staff and also patient left at 1500 hours – change of duties for nursing staff.*
>
> *b) Discharge Procedure not usual due to nausea and controlling same. Meds were not charted by anaesthetist and this was not noticed by nursing staff. Patient left ward at 1500 hrs – change of duty for nursing staff.*
>
> *c) Follow up appointment would have been 10 days.*
>
> *d) Patient went home Wednesday afternoon and did not contact anyone until Saturday 1400hrs when they called in as they were driving past.*
>
> *e) Usual take home meds would be panadeine or similar (probably panadol and voltaren 75mg SR).* [The consumer] *got panadeine from pharmacy.*
>
> *f) The Ward is open 24 hours and until 12.00pm on Saturdays. Patients are advised of this. If they have any worries or queries to contact the staff on duty*."

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Information Gathered During Investigation *continued*

The consumer advised the Commissioner that she "*suffered incredible pain after the operation – extremely excessive to others I have known to have the same operation*". The consumer said she was unable to contact the provider over the weekend when the pain became unbearable. She said she took panadol after discharge but was nervous about taking it because she did not know if it was okay to do so. She said family members attempted to contact the provider between Wednesday evening and Saturday morning but were unsuccessful. The consumer said that, on the advice of the surgical centre, she contacted the anaesthetist who was very helpful and arranged painkillers.

The provider stated that he had been contactable, through his office, until 5.00pm on Friday, 3 July 1998 and that, while he was out of the city for the weekend, there were no messages on his answerphone during this time. The provider said that the consumer did not make contact with him at his office in the week following the surgery and that, despite having a 24 hour, seven day answer service operating, she did not leave any messages with the service.

The provider advised the Commissioner:

> "*Subsequently, from information supplied to me by nursing staff at the* [surgical centre], *I am advised that* [the consumer] *took over-the-counter simple analgesic medication from the time of her discharge (Wednesday, 31st June 1998 at 4.00 p.m. until Saturday 4th July 1998. On that Saturday morning,* [the consumer] *and her father presented at the* [surgical centre], *advising the staff that* [her] *knee was painful, and requesting analgesic medication. I am advised that* [the consumer] *did not get out of the car to come into the* [surgical centre]. *The* [surgical centre] *staff contacted* [the anaesthetist], *who subsequently faxed an analgesic medication prescription through to a chemist.* [The anaesthetist] *subsequently telephoned* [the consumer] *at home to check that this had been achieved. The Senior Nurse at the* [surgical centre] *also telephoned* [the consumer] *at home on Monday, 6th July 1998 to check that all was well. I was not made aware of these above events either by* [the consumer], *the* [surgical centre] *staff, or by* [the anaesthetist]."

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Information Gathered During Investigation *continued*

The consumer advised the Commissioner that she returned to the physiotherapist for physiotherapy, attended every day and completed her daily exercises "*religiously*". She said that when she was more mobile she also attended the gym. The consumer said that the physiotherapist worked hard to try to rehabilitate her knee but "*in the end she felt there must be something wrong and advised me to go back to* [the provider]".

The physiotherapist's clinical records indicated that the consumer returned to physiotherapy on 6 July 1998. The physiotherapist noted that the consumer's knee had minus 20 degrees of extension and had flexion to 75 degrees. The physiotherapist performed soft tissue massage and interferential current (electrotherapy) on the consumer's quadricep muscles as well as active assisted knee flexion and extension exercises. Her plan consisted of a review in two days' time as well as a home exercise programme to be undertaken three times a day in order to increase the consumer's range of motion.

On 8 July 1998 the physiotherapist's records indicate that the consumer felt her quads were "*starting to work better*". Loss of extension remained at 20 degrees, with flexion to 70 degrees. Treatment was that received on 6 July 1998 as well as "*increased home programme exercises*" which the physiotherapist advised the Commissioner were to provide added end range pressure.

On 13 July 1998 the physiotherapist noted that the consumer was "*now walking with one crutch*". She observed that the consumer was "*still inflamed over knee*". The physiotherapist's plan included advice that the consumer should "s*tart hydrotherapy exercises and calf and hamstring stretches*".

On 15 July 1998 the physiotherapist noted that the consumer was "*feeling a bit better*", that she had reducing pain and that she had been in the pool twice. She also noted that the inflammation and tenderness in the consumer's right knee were decreasing. The consumer had an extension loss of 15 degrees and flexion to 75 degrees at this time. The physiotherapist's treatment included flexion/extension and contraction/relaxation stretches to the end of range.

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Information Gathered During Investigation *continued*

The consumer attended a follow up consultation with the provider on 16 July 1998. The consumer advised the Commissioner that the provider told her she should be more improved than she was. She said she told the provider that she had been trying really hard but was made to feel "*bad*" and "*guilty*" and the provider gave the impression that she was not trying hard enough. The consumer said she felt that the provider was not listening to her.

The provider wrote to the general practitioner following the consultation on 16 July 1998 and advised:

> "[The consumer] *is now two weeks following arthroscopic right knee ACL reconstruction. I was concerned to see that* [she] *has developed quite a stiff knee – she has a loss of 20 degrees of full extension, and is only flexing to 70-80 degrees. I have recommended she return to see her physiotherapist on a daily basis, and I stressed to her the need to do her exercises regularly, despite the fact that her knee is still a little sore. I will be seeing her again in two weeks' time.*"

The provider advised the Commissioner that his standard instruction for patients who have undergone ACL reconstruction is that they must return to the physiotherapist. He said the consumer did not resume her post operative physiotherapy visits until 20 July 1998. The consumer disputed this and advised the Commissioner "*not unless I gave him the wrong date*".

The consumer attended physiotherapy on 17 July 1998. The physiotherapist's records indicated that the provider was not happy with the consumer's range of movement. Records also indicated that the consumer had minus 15 degrees extension and flexion to 85 degrees.

On 20 July 1998 the physiotherapist noted in the clinical record that the consumer was "*complaining of pain in knee. Walking without crutches – no problem.*" She had minus 15 degrees extension and flexion to 80 degrees.

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Information Gathered During Investigation *continued*

On 21 July 1998 the physiotherapist noted that, post treatment, the consumer had extension loss of 10 degrees and flexion of 100 degrees with "*poor gait*" which was due to her fully weight bearing and not using crutches. The physiotherapist recommended the consumer start cycling in the gym, continue with pool exercises and start inner range squats.

The physiotherapist's clinical notes dated 22 July 1998 recorded that the consumer had:

> "*Tenderness on palpation + mild oedema thickening.*"

On 23 July 1998 the physiotherapist recorded that the consumer "*hasn't been able to get to gym yet*". At the end of treatment the consumer had minus 10 degrees extension and flexion to 100 degrees.

On 24 July 1998 the physiotherapist recorded "*cycling 1/7* [one day] *can't go full cycle yet*". The physiotherapist advised the Commissioner that this was because the consumer did not have 120 degrees of flexion.

On 27 July 1998 the physiotherapist recorded:

> "*Tripped over footpath today and bent right knee back suddenly. Pain ++.*"

The physiotherapist recorded that the graft was "*okay*" and that there was no instability. She noted increased inflammation in the consumer's right knee and that flexion had increased to 110 degrees. The physiotherapist advised the Commissioner that there was no structural damage as a result of the fall and the sudden stretch increased the consumer's range of movement. She did not report the fall to the provider because it was not a significant event.

On 28 July 1998 the physiotherapist recorded that the consumer's knee was "*aching a bit from fall*". She also noted that the consumer's loss of extension was 8 degrees.

On 29 July 1998 the physiotherapist recorded that the consumer was "*pushing it hard with gym exercises*".

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Information Gathered During Investigation *continued*

On 3 July 1998 the physiotherapist recorded that the consumer was "*sore after treatment pool exercises yesterday*". She recommended that the consumer start light resisted exercises in the gym and noted "*tight graft*".

On 5 August 1998 the physiotherapist recorded:

> "S*ome creps medial meniscus.*
> *A: ?tight graft/meniscus tear/loose body*
> *P: continue treatment – refer specialist for review – letter faxed to specialist*."

The physiotherapist wrote to the provider on 5 August 1998 advising those exercises that the consumer had been performing over the past three weeks. She stated:

> "*Thank you for your note concerning the slow progress of* [the consumer's] *recovery and intensity of her treatment.*
>
> *To date she has active ROM* [range of movement] *flexion 100 degrees and extension –15 degrees. Passive extension is –10 degrees (with overpressure).* [The consumer] *has worked hard with hydro exercises, cycling and resisted quads/hamstring and calf exercises in gym over the past three weeks. I have tractioned the knee (belt) and mobilised into flexion and extension with extreme overpressure but the knee remains stiff.*
>
> *I am baffled about the lack of progress. Is there any chance of meniscus or loose body blocking movement? Where to from here?*"

On 6 August 1998 the provider wrote to the general practitioner advising:

> "*Further to my letter of the 16th July,* [the consumer] *has not made good progress with regaining her right knee movement – she is five weeks following arthroscopic ACL reconstruction. She lacks the terminal 20 degrees of knee extension, and is only flexing to 80 degrees.*

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Information Gathered During Investigation *continued*

> *I think* [the consumer] *needs a manipulation of her knee done under anaesthetic, which I will do for her as soon as ACC approval comes through. She will then need to be attending her physiotherapist daily to maintain this movement.*"

The provider advised the Commissioner:

> "*At* [the consumer's] *second post operative visit, it was evident that she had made very little progress in restoring mobility in her knee. Her knee remained painful throughout, although I did not consider that she had any sign of either infection or reflex sympathetic dystrophy. At no time did I advise* [the consumer] *that 'the pain was in her head'. This statement implies that I had formed a diagnosis of central pain syndrome, which is not a diagnosis I would ever make without reference to a neurologist or pain management specialist.*
>
> Due to *[the consumer's]* delayed start with physiotherapy and subsequent lack of progress in regaining knee movement, a manipulation under anaesthetic had to be undertaken on 14 August 1998.*"*

The consumer advised the Commissioner that it was difficult to recall what the provider told her about the proposed manipulation but she understood he wanted to see how far he could straighten her leg under anaesthesia. The consumer said she told the provider that she could feel something was wrong and asked him to look at it while she was under anaesthesia, but the provider told her that there was no way anything could be wrong. The consumer said the provider was "*very cut and dried*" and told her he only needed to manipulate her leg and did not need to look at it surgically. The consumer said the provider told her the reason for the problem was "*increased scar tissue build-up*".

The manipulation was performed at the surgical centre on 14 August 1998. The provider wrote to the general practitioner on this date and advised:

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Information Gathered During Investigation *continued*

"*I did a manipulation of* [the consumer's] *right knee under general anaesthetic, a full range of flexion was achieved with breaking down of adhesions, though the terminal 2-3 degrees of extension could not fully be achieved. Her ligament graft feels to be intact.*

I have advised [the consumer] *to start seeing her physiotherapist on a daily basis, and to commit herself hard to an exercise programme to maintain her knee movement, and to restore muscle strength about the knee as soon as possible.*

I will be seeing [the consumer] *in one week's time.*"

The provider advised the Commissioner that he has performed over 1000 arthroscopic ACL reconstructions over nine years. He stated that this is the first time in his surgical experience a patient has developed a stiff knee following this procedure.

The consumer consulted the physiotherapist on 17 August 1998. The physiotherapist's clinical notes recorded:

"*O* [observation]*: Extension -8° post treatment – still stiff + pain ++*
A: ? [query] *meniscus lesion*
T *[treatment]*: mobilisations ++.*"*

On 19 August 1998 the physiotherapist's clinical notes recorded:

"*S* [subjective]*: same*
O [observation]*: no treatment*
T [treatment]*: as above*
P [plan]*: Review* – [the provider]
- suspect meniscal tear
- proceed to MRI/further arthroscope."

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Information Gathered During Investigation *continued*

The consumer consulted the provider on 21 August 1998. The consumer advised the Commissioner that the manipulation was "*not beneficial*" for her. She said she told the provider that she was working hard and that she was doing everything she could but said that he was "*not listening*". She said the provider told her that if she was not happy that there was nothing wrong (and that he had done the manipulation to prove it), she should obtain a second opinion.

The provider wrote to the general practitioner on 21 August 1998 advising:

> *"*[The consumer] *is now making some progress getting her right knee mobile, following a manipulation under anaesthetic on the 14th August 1998.*
>
> *However, she is still having a considerable amount of pain about the knee, compounded by a feeling of weakness due to muscle wasting. She has no signs of a reflex sympathetic dystrophy.*
>
> [The consumer] *has expressed herself dissatisfied with her progress and her overall situation, and I have hence suggested that my orthopaedic colleague ... offer her an opinion. I have stressed to* [the consumer] *that her knee problem is related to soft tissue tightness (capsulitis) about the knee and the solution to her problem, of loss of movement, is through a committed and intensive exercise programme. I have also been in touch with her physiotherapist.*
>
> *I will be seeing* [the consumer] *in three weeks' time.*"

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The physiotherapist advised the Commissioner that the provider told her he believed the consumer was not pushing herself hard enough. The physiotherapist said she told the provider that the consumer was pushing herself "*to the point of tears*". The physiotherapist said the provider was happy there was no meniscal impingement but suspected there was capsular adhesion.

The provider wrote to his colleague, an orthopaedic surgeon, on 21 August 1998 and advised:

> "*I would be grateful if you could help me out with a second opinion on this patient.*
>
> *I undertook an arthroscopic ACL reconstruction for her on the 30th June 1998. Her graft was fixed in full extension and there was no evident notch impingement. Post operatively, she was in a considerable amount of pain, though there was no evident reason for this. From the outset, her progress with physiotherapy was slow, and despite exhortation she failed to maintain her knee movement.*
>
> [The consumer] *has been seeing* [the physiotherapist] *for a physiotherapy programme and it is evident that a fair amount of work has been put in. Despite this,* [the consumer's] *knee remains stiff, and I undertook a manipulation under anaesthetic for her on 14th August 1998. At MUA* [manipulation under anaesthetic], *her knee fully flexed with breaking down of adhesions, though I could not get the terminal 3-5 degrees of extension back. On review today, she has flexion contracture of 8-10 degrees, and is now flexing to 90-100 degrees. She has marked muscle wasting. There are no signs, in my opinion, of RSD apart from her pain level, which seems to be settling.*
>
> [The consumer] *has formed the idea that there is 'something wrong inside the knee'. I have stressed to her that this is not the case, and that the solution to her problem lies in her accepting that she has had an adverse reaction of a capsulitis with subsequent contracture, and that while this is taking its natural course of resolution, that she must physically work very hard to regain and maintain her knee movement and muscle strength ….*"

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The consumer advised the Commissioner that her mother called the provider's rooms to make an appointment on her behalf. The consumer said the provider's secretary stated "*it's not our problem she doesn't do her exercises*". The consumer said this comment reinforced that the provider was not listening to her and was dismissive of that fact that she had been doing her exercises.

The provider advised the Commissioner that that his secretary/PA:

> "*... categorically denies that she made this statement ... and I have no reason to doubt* [her] *veracity in this regard.*"

The physiotherapist's clinical notes dated 25 August 1998 recorded:

> "*S* [subjective]*: Specialist has referred her to* [second orthopaedic surgeon] *for second opinion.*
> *Spoke to* [the provider] *who is happy there isn't any meniscal impingement but suspects capsular adhesion*
> *Range of movement post treatment extension -5° flexion 115°.*
> *P* [plan]*: Specialist has requested we push on with treatment.*
> *T* [treatment]*: as above.*"

The physiotherapist's clinical notes dated 27 August 1998 recorded:

> "*S* [subjective]*: Stiff and sore*
> *O* [observation]*: Flexion 110° pre treatment 120° post treatment*
> *T* [treatment]: *Flexion mobilisations with belt anterior glide + end of range oscillations 3x20.*"

The physiotherapist's clinical notes dated 1 September 1998 recorded:

> "*S* [subjective]*: as above*
> *O* [objective]*: End of treatment -2° extension*
> *T* [treatment]*: as above.*"

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Information Gathered During Investigation *continued*

The provider wrote to the general practitioner on 11 September 1998 following a consultation with the consumer. He advised:

> "[The consumer] *has now made real progress rehabilitating her right knee – she lacks the terminal 2-3 degrees of knee extension only, and 10 degrees of full flexion. Pain from the knee has largely settled down. Her muscle strength is still quite down, but she is working hard on this. Her graft feels to be intact. I have arranged to see* [the consumer] *again in one month's time.*"

The physiotherapist's clinical notes dated 4 September 1998 recorded:

> "*Woke this am with sharp pain base of neck. ...*"

Treatment consisted of therapy to the neck.

The physiotherapist's clinical notes dated 8 September 1998 recorded:

> "*S: Slowly improving*
> *O: extn -8° flexion post treatment 130°*
> *T: traction flexion mobilisations with belt fixation.*"

The physiotherapist's clinical notes dated 17 September 1998 recorded:

> "*S: Still complaining of medial knee pain.*
> *O: post treatment -4° extension 130° flexion.*"

[The provider's colleague] wrote to the provider on 17 September 1998 following a consultation with the consumer. He advised:

> "*Thank you for asking me to see* [the consumer], *for a further opinion following her cruciate ligament reconstruction.*

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Information Gathered During Investigation *continued*

As you know, this was carried out on 30/06/98, with a central third ligamentum patellae graft and no abnormality noted in the knee. Graft fixation was with an RCI screw at one end and a staple at the other end. The patient tells me that when she awoke from anaesthesia she was very sore and had to spend two days in hospital. The pain had abated to some extent, but has never disappeared in the knee and has limited her progress. She appears to have put in a fairly extreme amount of work into getting the knee going, but despite that of course was limited in her progress and required an MUA on 14/08/98.

Since that time she has regained further flexion and extension, although the latter gain has been fairly minimal. The joint has continued to be uncomfortable and this occurs when she is walking and when she is exercising. The joint swells a little, at times becomes hot and at times gets a purple discoloration around the medial aspect of the wound on occasion. She's also had some pins and needles on both sides of the joint, although this is fairly mild. She continues with a very vigorous programme, both at the physiotherapy and at the gym. She is swimming, using a rowing machine and generally working very hard to get muscle strength back again.

Examination revealed a knee range from 8-130 degrees. She had tenderness along the medial joint line and she had a positive McMurray test. The Lachman was barely positive, with a good solid end point. The collateral ligaments, lateral side of the joint, and patellofemoral joint seemed fine. Her quads, particularly more distally, were wasted, but she had excellent hamstring activity.

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My feeling is that she is improving now following your MUA, and I have encouraged her to continue with her physiotherapy programme and muscle strengthening. I think there are some very subtle signs of a slight complex regional pain disorder and for this reason I have given her some Transdermal Catapress which may settle down some of the discomfort. One would wonder about the possibility of something going on along the medial joint line and this may well require imaging if this doesn't settle. MR remains a possibility here although with the staple in place there may be enough artefact to reduce image quality.

The other choice of course is an arthrogram. She asked about arthroscopy of the joint and I have suggested that my approach would be to image the knee further before considering it. One would also want the joint freed up as much as possible and the pain settled before another surgical episode, as of course one would not want to flare up the problems with other operative intervention. However, if she remains stiff then an arthrofibrolysis may be a future possibility. She plans to see you in the very near future to review her problem again, and I was pleased to meet such a positive and motivated patient."

The provider advised the Commissioner:

"*However, over the subsequent twelve months, this anterior cruciate ligament graft has dissolved within the knee, and between* [my colleague] *and myself, we can offer no clear explanation of this. However, all of us involved in ACL reconstructions have experienced this phenomenon, although it is rare, and the cause is not known. It is presumably related to an adverse chemical/enzymatic environment within the knee leading to destruction of the ligament graft.*"

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Information Gathered During Investigation *continued*

The physiotherapist's clinical notes recorded that the consumer consulted her on 22 and 25 September 1998. On 19 October 1998 clinical notes recorded:

> "*S: no treatment*
> *O: Pre treatment flexion 140° extension -8° Post treatment extension -2°.*
> *T: as above*
> *P: Review* [provider's colleague]. *Push for arthroscopy.*"

The consumer saw the physiotherapist on 23 October 1998. The physiotherapist's clinical notes recorded:

> "*S: no change. Has booked an appointment with* [provider's colleague] *in 1 week.*
> *O: as above.*
> *T: as above.*
> *P: push for further arthroscopy.*"

The physiotherapist's clinical notes dated 30 October 1998 recorded:

> "*S: complaining of stiffness and pain end of range extension. To see specialist one week.*
> *O: tenderness on palpation in popliteal fossa* [back of knee]
> *T: belt extension mobilisations (as above)*
> *Post treatment range of movement extension -2° pain end of range.*"

Notes dated 4 November recorded "*no change*".

Notes dated 6 November 1998 recorded:

> "*S:* [Provider's colleague] *now requested MRI*
> *O: increased extension -2°*
> *T: belt traction/extension mobilisations with internal/external rotation end of range x 10.*
> *P: continue 1 x weekly maintenance mobilisations.*"

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Opinion – Case 99HDC07599/JS, continued

Information Gathered During Investigation *continued*

On 13 November 1998 The physiotherapist's clinical notes recorded:

> "*S: Sore today after circuit gym.*
> *O: Tight quad muscles and gastrocnemius insertions*
> *T: deep tissue massage*
> *P: awaiting MRI.*"

On 20 November 1998 the provider's colleague wrote to the provider advising:

> "[The consumer] *came back to see me again, still dissatisfied with her knee and the previous cruciate ligament reconstruction. The knee has continued to be painful and she now feels that it's not stable. She has experienced pain posteriorly, and medially and is quite limited in many activities. As you know, she has been a* [sportsperson] *and has done this professionally. She also teaches and finds that she can't bend down to help the children in a satisfactory fashion.*
>
> *Examination of the knee reveals limitation of flexion of the last 5 degrees and extension to the last 8 degrees. However, her extension range can be improved following prolonged stretching. The patient now has a positive Lachman test, of grade 2, and a slightly positive pivot shift.*
>
> *The pain she finds of significant concern, and it's a question here as to whether there is any meniscal pathology for instance which is causing this. It would also be interesting to know what the graft of the knee looks like, and I think that she needs further investigation. I think the best way of doing this, despite the risk that one may be restricted with a metal artefact, is to do an MR scan of the knee and we've written to ACC asking their permission to go ahead with an MR. An arthroscopy may be later required, but I'm just a little reluctant to push ahead with that as a first manoeuvre, because of her history of regional pain disorder.*"

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Information Gathered During Investigation *continued*

On 9 December 1998 the provider's colleague wrote to the general practitioner advising:

> "*I was pleased to see* [the consumer's] *MR scan, which reveals a possible tear of the lateral meniscus, of the right knee. As you would have seen, the anterior cruciate graft appears to be intact, with signal intensity within normal limits. However, what has been MR scanned has not been shown what is the tension of this graft.*
>
> *I have spoken to* [the consumer] *whose knee pain continues. I think the most reasonable thing here is to do an arthroscopy and possible partial meniscectomy. I don't think that going back and replacing the graft is sensible, and instead one would like to maximise range of movements, and to rehabilitate her as much as possible. I've mentioned that later graft reconstruction might be necessary, if instability continued to be a difficulty, and that the risks of arthrofibrosis, chronic pain etc, with further surgery of a more major type, at this stage I believe it too high.*
>
> *We'll apply to ACC for permission to do this arthroscopy and will keep you in touch with progress.*"

The provider's colleague performed the partial medial meniscectomy on 8 February 1999. The operation note recorded:

> "*Findings.*
>
> *1. Normal patella.*
> *2. Suprapatella pouch with large fibrinous band running through it and an area of thickened fibrous tissue which seemed to be joining the suprapatella pouch from underlying femur and possibly causing restriction in terminal movement. This was resected. Some tissue was resected from the medial paracondylar gutter as well. The overall amount of fibrotic tissue was mild.*
> *3. Medial articular surfaces with a number of chondral flaps and mild softening of articular cartilage in the flexion area of the femur. The level of chondral damage was grade 2.*

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Information Gathered During Investigation *continued*

4. Largely satisfactory medial meniscus, whch was stable around its periphery, however, there was a piece of tissue in the intercondylar notch which may have been evidence of an extremely narrow bucket handle, or it may also have been evidence of a cruciate remnant which had not been resected. This was prolapsing freely into the medial compartment, and causing catching. It was resected.

5. Anterior cruciate ligament which was lax to probling, but appeared to be intact. The cruciate was impinging on the anterior and distal end of the intercondylar notch causing the difficulties with knee extension. There was a humped area of fibrotic tissue around the cruciate tibial insertion and this was resected, leaving cruciate fibres intact. There was an amount of thickened and dense connective tissue in the roof of the notch an this was curetted. This allowed some improvement in knee extension.

6. Normal lateral meniscus.

7. Softening of lateral tibial articular surfaces,w ith a fissure under the lateral meniscus, with the probe sinking to bone in this area. The rest of the tibial articular surfaces were somewhat softened.

Knee well lavaged, and wounds closed with steri-strips, compressive bandage applied and patient returned to ward for early discharge. To return to clinic in two weeks' time."

On 22 April 1999 the provider's colleague wrote to the general practitioner advising:

"*I was pleased to see* [the consumer] *today, to further discuss her knee problems.*

HISTORY: As you may be aware, the joint is still mildly uncomfortable, and seems to tighten with activity. It will give way with any side stepping action, and is still not able to fully extend.

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Information Gathered During Investigation *continued*

As we noted in the prior arthroscopy, there seemed to be some impingement of the graft, in the roof of the intercondylar notch, and this may be the reason for difficulties with extension. Certainly the graft was very lax and again that's a cause of her giving way.

I have told [the consumer] *that it may well be possible to allow a little more knee extension, and to make the knee more stable with revision cruciate reconstruction. However, this would certainly not be guaranteed to get rid of the pain in the joint, and at prior arthroscopy, we did note a moderate degree of wear in her knee which may well be irreversible.*

She would very much like to go ahead with the surgery and I have talked to her in detail about the risks and benefits of this procedure. It seems very unlikely that she will continue to improve without intervention and she fully realises that with her previous damage etc, that one cannot make any guarantees regarding sporting function etc.

TREATMENT PLAN

DIAGNOSIS: 1) Failure of Prior anterior Cruciate Ligament Reconstruction – Requiring Revision. 2) Post Traumatic Chondral Damage.

PROCEDURE RECOMMENDED: Revision Arthroscopic Anterior Cruciate Ligament Reconstruction – Right.

CLINICAL PRIORITY: Moderate.

ACC PROCEDURE NO: KEE20. CPT CODE: 29888.

TREATMENT PROVIDER: [Hospital].

PRE & POST OPERATIVE CARE: The patient will be admitted on the day of surgery and will be likely to be discharged on the first post operative day. She will need of course physiotherapy and will need to mobilise with crutches for the first 2-3 weeks.

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Information Gathered During Investigation *continued*

PROGNOSIS: Prognosis is for a return to very satisfactory knee stability. She is liable to be able to return to her teaching job within a couple of weeks, but her ability to function as a professional [sportsperson] *in the future is in question. There is a 90% chance that we can produce very adequate stability in the knee, but there is chondral damage which may preclude her from carrying out some of these vigorous activities.*

ALTERNATIVE CARE: Nil recommended."

The consumer underwent a revision ACL reconstruction at a hospital on 17 June 1999. The operation note recorded:

"*PROCEDURE:*

Patient given a general anaesthetic, tourniquet applied, skin prepared and draped, and scope inserted through an anterolateral portal, and the prior ACL tissue was noted to be significantly hypertrophied, and lax.

There was a grade 2 pre-operative Lachman. The knee would not extend the last 5 degrees. The ACL was cleared in a piecemeal fashion and the screw in the femoral tunnel identified. The screw was removed and as much tissue as possible around the anterior part of the tibial spine also removed. Tissue removed also from the surface of the PCL, in an effort to get full extension. Paracondylar gutters were cleared maximally as well. This did not allow the last 3 degrees of extension.

The hamstring tendons were lifted using the Linvatec device, taking semi-tendonosis and gracilis to a length of 23cm, doubling them, and therefore performing a quadruple hamstring graft 7.5mm in diameter. This was held with a running 2 Vicryl stitch. Appropriate 7.5mm drill holes were placed and it was possible to avoid the previous Richard staple, by using an appropriate more posterior tibial entrance wound and starting the tunnel more medially. This gave a straight run into the femoral tunnel.

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Information Gathered During Investigation *continued*

Draw sutures were placed, and the graft was pulled into position and held with 2 RCI screws. Following this the abnormal Lachman test was completely obliterated, the knee would flex well, and again it was limited in the last 3 degrees of extension. This was irrespective of graft tightness or position.

The knee was lavaged, Redivac drains inserted, and the small wound closed with Vicryl and sub cuticular Maxon. Marcaine infiltrated, after steri-strips had been applied. The wound was bandaged.

Post Operatively for:

1. *Adequate analgesia.*
2. *Intravenous Kefsol.*
3. *Mobilisation weight bearing with crutches.*
4. *Standard Pincewski physiotherapy regime.*
5. *Review two weeks post operatively.*"

On 1 July 1999 the provider's colleague wrote to the general practitioner advising:

"*I was pleased to see [the consumer] today, who is delighted with her knee following further cruciate reconstruction.*

The joint is coming to within about 3 degrees of the other side in extension, and that was the only area that we couldn't get the range back to normal. However, I think with the careful stretching programme there is every likelihood that she will improve this range. Her flexion is now to within 10 degrees of the other side. Her thigh muscle is improving and her wounds look excellent. Her knee is completely stable.

The plan is to review her again in a month's time, and for her to avoid any twisting or open chain exercises in the meantime."

On 5 August 1999 the provider's colleague wrote to the general practitioner advising:

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Information Gathered During Investigation *continued*

"*I was very pleased to see* [the consumer] *today, who is doing very well following her cruciate reconstruction. The joint is stable and thigh muscle strength improving.*

The joint is moving nicely, and the only thing that she has noted is a little discomfort from time to time over the pes anserine area, with a wee bit of swelling. I've suggested some topical anti-inflammatory, and if this doesn't work, trying some oral anti-inflammatory.

I've not seen anyone develop any persisting pes anserine problems following hamstring graft ACL reconstruction, but I guess that is always conceivable, and a steroid injection would be a later possibility. However, the problem is fairly minor and I think can be pretty much left as is at the present time.

I'd like to see [the consumer] *again in two months.*"

On 7 October 1999 the provider's colleague wrote to the general practitioner advising:

"*I was pleased to see* [the consumer] *today who is making good progress with her knee. She is building up strength, but is finding that this is taking her a little longer than she would have thought.*

Her knee moves through a full range and there is not the slightest sign of ligamentous instability.

I think all is well here, and I have suggested that I see her again in three months' time.

She does note some clicking in the knee and I think that is patellofemoral, and I have reassured her that that should improve with further muscle strengthening."

Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Independent Advice to Commissioner

An independent orthopaedic surgeon, advised the Commissioner as follows:

"*I have reviewed the file forwarded.*

History:

The physiotherapy notes indicated [the consumer] *had injured the right knee on 17.5.98.*

Examination showed findings which were considered to indicate injury to the medial and anterior cruciate ligaments (ACL).

The knee lacked 20 degrees of extension and flexed to 90 degrees. Specialist referral was advised.

A referral letter was written by the general practitioner, on 11.6.98.

[The provider] *saw* [the consumer] *on 16.6.98.*

In a letter to the general practitioner of that date, [the provider] *states: - 'Despite her history of injury which is very suggestive of ACL rupture, I did not find her knee to have marked anterior laxity, and I suspect that the ACL rupture may only be partial. This would also account for her knee flexion contracture, which is often seen following a partial rupture.'*

Physiotherapy was continued, and on 17.6.98, there was noted to be a lack of 15 degrees extension and flexion to 90 degrees.

[The provider] *advised that the knee be examined under an anaesthetic, and an arthroscopy carried out. If there was evidence of an anterior cruciate ligament problem, he planned to proceed to a reconstruction operation.*

At operation on 30.6.98 (just over 6 weeks after the injury), examination showed no fluid in the joint. The collateral ligaments were intact, and there was evidence of an anterior cruciate ligament injury.

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Independent Advice to Commissioner *continued*

At arthroscopy, the joint surfaces of the patella and medial and lateral joint compartments were reported as normal.

There was a rupture of the anterior cruciate ligament.

An anterior cruciate ligament reconstruction operation was carried out, using the middle third of the patellar ligament.

The post-operative instructions were that she would be discharged on the following day.

The theatre record indicates that the operation commenced at 0740 hours and finished at 0840 hours.

The notes from the Post-anaesthetic Care Unit indicate that Pethidine was given intravenously.

25mg were given at 0905, 10mg at 0925, 15mg at 0935, 25mg at 1000 and 25mg at 1015 i.e. a total of 100mg over a period of 70 minutes.

During that period an ice pack had also been applied to the knee.

Pethidine 75mg intramuscularly had been charted by the anaesthetist before the operation.

This dose was given at 1215 and again at 2130.

Panadeine 3 tablets 4 hourly had also been charted. This was given at 1330, 1800 and 2200.

Panadeine was also given during the night at 0200 and 0630.

[The consumer] *was nauseated and medications were given for this.*

On 1.7.98 no further medications for pain relief were given during the day and she left hospital at 1500 hours.

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Independent Advice to Commissioner *continued*

Medications for pain relief were not prescribed on discharge from hospital, and apparently no advice was given regarding pain medication.

[The consumer] *called back to the hospital on Saturday 3 July. Following this* [the anaesthetist] *forwarded a prescription.*

Physiotherapy was continued following the operation.

It is apparent that [the provider] *considered the progress slow. She failed to regain extension past 20 degrees and flexed only to 80 degrees.*

The knee was manipulated under general anaesthetic on 14.8.98. Adhesions were broken down, and almost full extension obtained.

She saw [the provider's colleague] *on 17.9.98.*

Examination showed a range of movement of 8-130. The Lachman test (a test for the anterior cruciate ligament) was described as 'barely positive'.

When reviewed on 20.11.98, the knee remained painful, and there was now a positive Lachman test.

An MRI scan was advised.

This showed a possible tear of the lateral meniscus. The anterior cruciate graft appeared to be intact, with signal intensity within normal limits.

At arthroscopy on 8.2.99, fibrotic tissue was found in the suprapatellar pouch – the overall amount was described as mild. This tissue and a large band, in the suprapatellar pouch was resected.

The articular surfaces medially were noted to show a number of chondral flaps, and mild softening of the articular cartilage.

The anterior cruciate ligament was lax but appeared to be intact.

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Independent Advice to Commissioner *continued*

In the lateral joint compartment, there was softening of the articular surface.

The reconstructed cruciate ligament was impinging on the anterior and distal end of the intercondylar notch, which was considered to cause the difficulties with knee extension. A humped up area of fibrotic tissue, around the tibial insertion of the ligament was resected.

When reviewed on 22.4.99 the joint was still mildly uncomfortable, and seemed to tighten with activity. It gave way with any side stepping action, and could still not be fully extended.

At operation on 17.6.99 arthroscopy showed:- 'The prior ACL tissue was noted to be significantly hypertrophied and lax.'

The reconstructed ligament was removed, and a further reconstruction carried out using a graft from the hamstring tendons.

On review on 7.10.99, there was a full range of knee movement and no ligamentous instability.

Discussion and Opinion:

The records at the [surgical centre] *indicate that* [the consumer] *had rather more than the anticipated amount of pain, following the operation.*

Although the management of pain is ordinarily delegated to the anaesthetist, if the pain is greater than that usually experienced, it is the responsibility of the surgeon to be aware of this, in order to manage the medications for pain relief himself, or to seek further advice from the anaesthetist.

As far as I am able to determine, there were no instructions or advice given on what should be done, if there was concern of any sort before the first followup visit.

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Independent Advice to Commissioner *continued*

I am always very cautious in assessing the importance to be placed on the recall of conversations, and the significance of these conversations.

I note [the provider's] *comment that messages were not left on his answerphone, and again I find this difficult to assess.*

I know of some people who do not leave messages, feeling that they will not get through.

[The provider] *does not comment, and I would not expect him to recall, whether or not the answerphone recorded that there had been a call, and on retrieval there was no message.*

When [the provider's colleague] *first saw* [the consumer] *he recorded that the Lachman test was barely positive, and at arthroscopy on 8.2.99 the anterior cruciate ligament was lax, but appeared intact.*

At operation on 17.6.99 the Lachman test was definitely positive, and the anterior cruciate ligament lax.

This suggests that the graft had stretched over this period, and does not necessarily indicate that the graft was from the beginning lax.

However, any laxity of the graft, cannot explain the pain which was the main feature, not only in the early post-operative period, but also over the ensuing months.

It is apparent from the operative findings that [the provider's] *statement that 'however over the subsequent 12 months, this anterior cruciate ligament graft has dissolved within the knee' is incorrect.*

I am unable to offer a satisfactory explanation for the severity of the pain experienced in the early postoperative period.

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Independent Advice to Commissioner *continued*

It has however been my observation that, when surgery is carried out a few weeks after the original injury, there is often a more marked tissue reaction, as compared with when the operation is carried out, either within a few days or after several months.

To answer your specific questions:-

1. *There are no specific standards that apply to the management of this type of case apart from, that the surgeon should ensure that proper instructions should be given as to what should be done, in the event of the patient having concern.*

2. *Although the anaesthetist usually charts the post-operative medications, it is the surgeon's responsibility to check that the going home medications are available.*

   In this case as [the anaesthetist *was not* [the provider's] *usual anaesthetist, this is even more important.*

3. *The provider's advice that* [the consumer] *should have physiotherapy daily was reasonable. However, it is my opinion that even if she did not attend this could not be held responsible for the failure of the operation to achieve the expected result.*

4. *I am unable to give any accurate figures for the failure of an anterior cruciate ligament reconstruction operation to achieve the expected result. This depends on many factors including the patient's expectations.*

   The question of the significance of the impingement of the graft in the intercondylar notch is controversial. In this case, correction of the impingement did not correct the problem.

5. *The diagnosis of capsulitis is not unreasonable, and is only one of the factors that could give rise to limitation of movement. The others include fibrosis within the joint, which rarely can be gross and restrict movement markedly.*

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Independent Advice to Commissioner *continued*

6. In my opinion there is no evidence of any failure of surgical technique."

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Opinion: Breach
The provider

In my opinion the provider breached Right 4(1) of the Code in relation to the consumer's pain relief.

Right 4(1)

Pain relief
The provider advised that pain relief is charted by the anaesthetist but that the anaesthetist did not do this. My independent advisor noted that the management of pain is usually delegated to the anaesthetist but, in a situation where the patient is experiencing greater pain than normal, it is the responsibility of the surgeon to be aware of this in order to manage it or to take advice from the anaesthetist.

The provider saw the consumer on the morning of discharge. While he did not clearly recollect the level of pain the consumer was experiencing he said that if pain management had been an issue the nurses would have raised it with him and, more likely, with the anaesthetist. However, I note my advisor's comment that, because the anaesthetist was not the provider's usual anaesthetist it was important that the provider check pain medication had been charted for discharge. In the circumstances I do not accept the provider's statement that, because he was not told the consumer had been experiencing significant pain prior to discharge, he was not alerted to check what discharge medication had been requested.

The provider and the consumer disagreed about his availability in the week following discharge and I make no finding on this point. However, assistance was available from staff at the surgical centre and I note that the consumer's father took advantage of this the following Saturday.

I also note that the consumer's follow-up appointment with the provider was two weeks after discharge.

In all the circumstances I conclude that the provider, as the surgeon with overall responsibility for the consumer's admission, surgery and discharge, was responsible for ensuring that she was sent home with adequate pain relief. In my opinion the provider did not provide services with reasonable care and skill and breached Right 4(1) of the Code.

Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Opinion: No Breach The provider

In my opinion the provider did not breach Right 4(1) of the Code in relation to the consumer's surgery.

Right 4(1)

Surgery

The consumer was concerned that, despite attending physiotherapy regularly, completing her home exercise programme and working out at the gym, her knee was not improving as expected, and she continued to experience pain. The consumer said the provider dismissed her efforts at rehabilitation and told her that her pain was in her head. The provider disputed making this statement. However, it is clear that he did not accept there was anything wrong with the graft itself and determined that the problem was caused by capsulitis. His recommendation was that the consumer should undertake a strict physiotherapy programme. I accept that the consumer would have been frustrated by this advice, given the amount of work she was putting into her rehabilitation, which her physiotherapist stated "*was to the point of tears*".

I note the advice of my independent expert that the provider's diagnosis of capsulitis was not unreasonable in the circumstances and that there was no evidence of any failure of surgical technique. I also note that, following the manipulation under anaesthetic, the provider referred the consumer for a second opinion when she continued to express dissatisfaction with the progress she was making and the amount of pain she was continuing to experience.

The consumer advised me that when she saw the provider's colleague, who performed an ACL repair, her knee felt better almost immediately. However, during her first consultation with him, the provider's colleague felt that the consumer was improving following the manipulation under anaesthetic and he encouraged her to continue with the physiotherapy programme and muscle strengthening.

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Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Opinion: No Breach The provider *continued*

My advisor commented that a barely positive Lachman test on that occasion and a "*definitely positive*" Lachman test in November 1998 suggested that "*the graft had stretched over this period, and does not necessarily indicate that the graft was from the beginning lax*". I note my expert's advice that a subsequent correction of the impingment, on 8 February 1999, did not correct the problem that the consumer was experiencing and she was required to undergo further surgery with the provider's colleague on 17 June 1999.

I conclude that the provider provided surgical services with reasonable care and skill and did not breach Right 4(1) of the Code.

The provider's secretary
The consumer advised me that, when her mother telephoned to make an appointment with the provider, his secretary told her that it was not his fault that the consumer was not performing her exercises. The provider's secretary denied making this comment. In light of the conflicting evidence, I make no finding on this point.

Opinion: Breach surgical centre

In my opinion the surgical centre breached Right 4(1) of the Code.

Right 4(1)

The surgical centre provided theatre facilities to the provider and overnight nursing care to the consumer. The fact that discharge pain relief was not charted, either by the anaesthetist or the provider, was overlooked by nursing staff. The manager of the surgical centre advised me that this happened because the discharge procedure was unusual, due to the consumer's previous nausea and efforts to control it, as well as the fact that nursing handover took place at the time of discharge. However, in my opinion, nursing staff should have been alerted to the lack of take-home pain relief. It is no excuse that they were distracted by the consumer's previous care needs or by handover.

In these circumstances I conclude that the surgical centre did not provide services with reasonable care and skill and breached Right 4(1) of the Code.

Orthopaedic Surgeon/Surgical Centre

Opinion – Case 99HDC07599/JS, continued

Actions

I recommend that the provider takes the following action:

- Apologises to the consumer in writing for his breach of the Code. The apology is to be sent to the Commissioner and will be forwarded to the consumer.

- Checks whether take home pain medication has been charted when he is reviewing a patient for discharge.

I recommend that the surgical centre takes the following action:

- Apologises to the consumer in writing for its breach of the Code. The apology is to be sent to the Commissioner and will be forwarded to the consumer.

- Reviews its nursing practice in light of this report.

Other Actions

A copy of my report will be sent to the Medical Council of New Zealand.

An anonymised copy of my report will be sent to the Royal Australasian College of Surgeons for education purposes.