Assessment prior to anaesthetic procedure (12HDC00991, 26 November 2013)

Anaesthetist ~ Epidural steroid injection ~ Standard of care ~ Inadequate examination ~ ANZCA standards ~ Documentation ~ Professional boundaries ~ Rights 4(1), 4(2)

A woman complained about the services provided by an anaesthetist at a private clinic, where she underwent an epidural steroid injection.

The woman was referred to the anaesthetist by her sports physician for consideration of an epidural steroid injection to help treat her chronic lower back and left leg pain. After speaking with the anaesthetist twice on the phone, she attended a consultation.

The woman took a support person with her to the consultation. The anaesthetist asked the woman about her history and conducted a brief physical examination. There is no evidence that the anaesthetist gave adequate consideration to the woman's history and symptoms, and he did not conduct a sensory examination. The anaesthetist documented in his notes that the woman had mostly mechanical low back instability with a suggestion of radiculopathy but no nerve root compression.

During the consultation, the anaesthetist talked at length about his own health. After almost two hours in the consultation, the anaesthetist explained the risks and benefits of the epidural steroid injection, and the woman decided to proceed.

The Australian and New Zealand College of Anaesthetists (ANZCA) standards for epidural injections require appropriate assistance for major regional analgesia and that adequate sterile precautions are taken. The anaesthetist did not have an assistant present during the procedure and did not wear a gown or mask. The anaesthetist did not record his method of identifying the epidural space or loss of resistance, or any observations made during the needle placement.

The woman experienced significant pain following the procedure and cancelled her follow-up appointment with the anaesthetist. The anaesthetist did not contact the woman after the procedure.

It was held that the anaesthetist did not conduct a thorough examination of the woman prior to the epidural procedure, breaching Right 4(1) of the Code. It was also held that the anaesthetist's failure to use an assistant, his inadequate sterile precautions, and his failure to document his identification of the epidural space or loss of resistance, or whether there was any paraesthesia or fluid backflow, did not comply with professional standards and therefore breached Right 4(2) of the Code.

The anaesthetist also introduced his own health condition into the consultation, which had the effect of making the woman feel that her experience was being minimised and devalued, breaching Right 4(2) of the Code.