Anaesthetist, Dr B

A Report by the

Health and Disability Commissioner

(Case 12HDC00991)

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Executive summary

1. Since suffering a back injury in an accident in 1988, Mrs A had experienced chronic pain in her back to varying degrees. On 6 January 2012, Mrs A rose from a chair and felt a popping sensation in her lower back. On 29 February 2012, Mrs A visited a sports physician, Dr C, on a referral from her physiotherapist. Dr C reviewed X-rays and ordered an MRI scan, following which he referred Mrs A to an anaesthetist, Dr B, for consideration of an epidural steroid injection.

2. On 23 April 2012, Mrs A and her support person consulted Dr B in his private consulting rooms. By the date of the appointment, Dr B had received only a brief referral note from Dr C and Mrs A's most recent MRI scan. He had not received the more detailed letter that he told HDC he would normally receive. Dr B asked Mrs A about her history and conducted a brief physical examination. He documented in his notes that Mrs A had mostly mechanical low back instability with a suggestion of radiculopathy[1] but no nerve root compression.

3. During the consultation, Dr B talked at length about his own health. Mrs A felt that, by doing so, he minimised her experience. She also found Dr B to be rude and disrespectful.

4. After almost two hours in the consultation, Dr B explained the risks and benefits of the epidural steroid injection, and Mrs A decided to proceed. Dr B asked Mrs A to loosen her trousers and he pulled them down to allow adequate exposure of her lower back. He did not ask Mrs A before doing this, and he did not offer her a blanket, despite Mrs A's support person requesting one.

5. Dr B did not have an assistant present during the procedure. Dr B's sterile procedure involved disposable prepacked trays, gloves, and a no-touch technique. He did not wear a gown or mask. He used a 22g spinal needle. He did not record his method of identifying the epidural space or loss of resistance, or any observations made during the needle placement.

6. Mrs A experienced significant pain following the procedure. Dr B did not contact Mrs A after the procedure as patients are told to contact him if they have any concerns. On 10 May, Mrs A sent an email to Dr B cancelling her follow-up appointment. She described her physical reaction and pain levels after the procedure, and explained that she was seeing Dr C. Dr B advised that he did not receive that email. However, Dr B did speak with Dr C on approximately 17 May to discuss possible treatment options.

Findings

7. Dr B did not conduct a thorough examination of Mrs A prior to the epidural procedure and, accordingly, breached Right 4(1)[2] of the Code of Health and Disability Services Consumers' Rights (the Code).

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[1] Radiculopathy is irritation of the spinal nerve roots and/or spinal nerves. It is often characterised by pain that radiates out from the spine to other parts of the body, such as the leg or arm.

[2] Right 4(1): "Every consumer has the right to have services provided with reasonable care and skill."

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8. Dr B did not use an assistant, his sterile precautions for the procedure were insufficient, and he failed to document his identification of the epidural space or loss of resistance, or whether there was any paraesthesia[3] or fluid backflow. In these respects, Dr B breached Right 4(2)[4] of the Code.

9. Dr B also introduced his own health condition into the consultation, which had the effect of making Mrs A feel that her experience was being minimised and devalued. In these circumstances, Dr B breached professional boundaries and, accordingly, breached Right 4(2) of the Code.

Complaint and investigation

10. The Commissioner received a complaint from Mrs A about the services provided by an anaesthetist, Dr B. The following issue was identified for investigation:

- *The appropriateness of services provided to Mrs A by Dr B on 23 April 2012.*

11. An investigation was commenced on 11 March 2013. The parties directly involved in the investigation were:

Mrs A	Consumer/Complainant
Dr B	Provider

12. Information was also reviewed from Dr C, sports physician/referring doctor.

13. Independent expert advice was obtained from an anaesthetist, Dr David Jones (**Appendix A**).

Information gathered during investigation

Mrs A's back pain

14. As a consequence of an injury in 1988, Mrs A suffered a crush fracture to the T12[5] disc of her spine. In 2002, she had a four-level spinal fusion[6] from T10 to L2, involving the insertion of a titanium cage, rods and screws.

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[3] Paraesthesia is spontaneously occurring abnormal skin sensations (such as tingling, tickling, itching or burning), usually associated with peripheral nerve damage.

[4] Right 4(2): "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

[5] Discs in the spine are referred to by letter (indicating the section of the spine, such as T=Thoracic, L=Lumbar) and number (indicating the disc number in that section), with higher numbers corresponding to discs lower down the spine.

[6] Spinal fusion surgery is designed to stop the motion at a painful vertebral segment, which in turn should decrease the pain generated from that joint.

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15. The spinal fusion operation helped Mrs A to regain her spinal stability and improved the pain in her right leg. However, she continued to experience chronic lower back and left leg pain, and had pain when sitting. She tried several different pain medications and consulted a number of back specialists and chronic pain specialists, but none of the treatments successfully relieved the pain.

16. On 6 January 2012, Mrs A rose from a chair and felt a popping sensation in her lower back. She experienced severe pain in her lower back, which spread to her left leg, general numbness and tingling in her foot and big toe, as well as weakness and instability in her left leg. Her ability to sit for any period was further reduced.

Referral to Dr B for epidural steroid injection

17. On 29 February 2012, Mrs A visited a sports physician, Dr C, having been referred by her physiotherapist. After reviewing her X-rays, Dr C diagnosed Mrs A with a sprain to her lumbar spine and lumbar disc radiculopathy,[7] which was likely to have been caused by a prolapse putting pressure on a nerve. Dr C considered that Mrs A's previous spinal fusion surgery was probably a causative factor for this injury, as it would have increased pressure on her remaining moving lumbar segments. Dr C referred Mrs A for an MRI scan.

18. The MRI scan report noted:

> "Satisfactory post fusion appearances and no evidence for spinal stenosis or nerve root compromise in the mid to lower lumbar region. Minor, broad-based disc bulges at several levels [L3/4, L4/5 and L5/S1] are not causing any lateral recess or foraminal stenosis."

19. Dr C documented in his notes that the finding on MRI was consistent with Mrs A's back pain and subsequent left leg pain. After discussing the scan results with Mrs A, Dr C referred her to an anaesthetist, Dr B, for consideration of an epidural spinal steroid injection.[8]

20. Mrs A arranged an appointment with Dr B for 23 April 2012. She told HDC that she spoke with Dr B twice prior to the appointment. In these conversations, they discussed what the procedure involved, and Mrs A told Dr B of her major spinal surgery in 2002. Dr B confirmed that he spoke with Mrs A twice before the appointment, but he did not provide any details of the discussions he had with Mrs A at those times. In response to the provisional opinion, Dr B said that he receives a number of calls on his mobile phone from patients, and it is "impossible to remember which patient said what 12 months later".

Assessment of Mrs A by Dr B

21. On 23 April 2012, Mrs A and her support person consulted Dr B in his private consulting rooms. Mrs A said that Dr B greeted her by asking her who she was and why she was there. Mrs A said she found this greeting rude and disrespectful.

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[7] See footnote 1 above.

[8] An epidural steroid injection involves the injection of a long-lasting steroid (often with an anaesthetic) into the epidural space of the spine. The epidural space is a fatty sheath that surrounds the spinal sac and provides cushioning for the nerves and spinal cord.

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22. Dr B had received only a brief referral note from Dr C, dated 27 March 2012, and Mrs A's most recent MRI scan. Dr B told HDC that normally the faxed referral note from the clinic is followed by a more comprehensive letter by mail. However, in this case he realised that he had not received that letter only when Mrs A presented for her appointment, and this was the reason for his questions when she arrived. Dr C's referral note of 27 March 2012 stated:

> "Thank you for seeing [Mrs A] who presents with Lt leg radicular symptoms with an MRI scan confirming disc bulges posteriorly in the lower 3 levels with foraminal narrowing in the lower two levels.
>
> [Mrs A] had 4 level fusion by Dr […] 10 years ago. She is working with [a physiotherapist] on spinal rehabilitation.
>
> For consideration of an epidural steroid injection."

23. Dr B told HDC that he felt able to proceed with the consultation with Mrs A without the detailed referral letter, by asking Mrs A about her history and making his own assessment of her pain (which he said he would normally do in any event). He asked Mrs A a number of questions about her medical history. Mrs A told HDC that she did not feel that Dr B listened to her responses, and that he frequently interrupted and talked over her. Dr B advised that his impression was that he and Mrs A had a good discussion about her chronic pain, and that there was good dialogue during the consultation.

24. During the discussion, Dr B talked at length about his own health, including that his ACC claim had been denied. Mrs A told HDC that she felt that Dr B's comments about ACC were a criticism of her use of ACC. Dr B told HDC that Mrs A took his comments "totally the wrong way". In response to the provisional opinion, Dr B noted that ACC declined his claim because they attributed his injury to an ongoing degenerative process and he was not being critical of Mrs A.

25. Mrs A said that she asked Dr B if they could look at her MRI scans. She told HDC that Dr B's review of the scans seemed very brief, and that he told her they were normal. Dr B's clinical notes record his view that the MRI images showed minimal bulging of the lower lumbar discs, with no nerve root compression. He advised HDC that the minor disc bulges noted on the MRI would not be abnormal for someone of Mrs A's age.

26. Mrs A recalled that Dr B spent at least 15 minutes discussing details of his own health condition and explaining his pain experience and management. She said that he made comparisons between his own condition and Mrs A's. Mrs A told HDC that she found this approach "highly unethical and unprofessional". In response to the provisional opinion, Dr B said that mentioning his own health was an attempt to be empathetic, and not to minimise Mrs A's condition.

27. Dr B told HDC that he shares details of his health condition with patients not to demonstrate pain, but rather to help people to understand their condition and to illustrate how they can manage to cope and lead a reasonably functional life.

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28. Mrs A felt that he minimised her experiences, by saying he would show her "what real bulging and real pain looked like".

29. Mrs A asked Dr B the cause of her lower back and left leg pain. She recalled that Dr B told her that she had mechanical back pain like many woman of her age. Mrs A found this comment to be a broad assumption and derogatory to women of her age. Dr B advised HDC:

> "[Mrs A] had the impression that the disc bulging was the cause of her pain and that the degree of bulging she had is common and in her scans the disc was not in contact with any nerve roots and if so would give her a more severe and constant pain down the leg which in her case was minor and intermittent. Scans are done with patient in the supine position but when patients are in a weight bearing position then contact with the nerve root can occur and symptoms of radiculopathy can occur which I felt was in [Mrs A's] case and hence the epidural [sic]."

30. Dr B suggested that Mrs A review her pain management therapy, and look at doing mental and physical exercises. Mrs A stated that she had developed excellent strategies for managing pain but that her pain had increased after excessive loading on her lumbar-sacral area caused by an increase in sitting.

31. Dr B told HDC that he examined Mrs A's posture, how she stood, the tenderness of her whole spine, and her range of movements, and looked for any evidence of nerve root irritation. He documented in the clinical notes that Mrs A had only ten degrees of flexion and her lumbar movements were very restricted. He also examined the scar on her back from her spinal fusion surgery, and noted that she was "very tender to pressure over L3 to S1". Dr B told HDC that he did not conduct the sensory tests of light touch or pin prick because Mrs A gave no history of impaired sensation or allodynia.[9] Dr B recorded in the clinical notes: "Has mainly mechanical low back instability with a suggestion of left L5/S1 radiculopathy."

Decision to proceed with epidural

32. After a consultation of almost two hours, Dr B explained the risks and benefits of the epidural steroid injection. Dr B told HDC that he gave Mrs A a lengthy explanation about the procedure, including that it is of less benefit for mechanical back pain and that it is less effective after major back surgery.

33. In response to the provisional opinion, Dr B said that "overall I felt there was enough evidence to warrant [an] epidural steroid for her radiculopathy but not the mechanical back pain which I felt was causing more for suffering for [Mrs A] for which she has seen 7 specialists over the last 24 years hence the extra time spent in consultation [sic]".

34. Mrs A confirmed that Dr B provided her with an information sheet about the procedure. The information sheet is headed, "Therapeutic Epidural Injection", and it states, in part:

[9] Allodynia occurs where a person experiences a painful reaction to a stimulus that is not normally painful.

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> "**Indication**: For the treatment of radiculopathy (nerve root irritation). It is of less benefit in mechanical low back pain and spinal stenosis …
>
> **Procedure**: It is performed under local anaesthetic and the level of injection depends on the level of the nerve involved. Triamcinolone 80–100mgms in 10–20 mls of saline is injected. The aim is to reduce the irritation around the nerve root and surrounding tissues. The medication is released over the 3 weeks so the response is not instant. Access to the space may be more difficult in the elderly, previous back surgery and obese because of degeneration and depth …
>
> **Side effects**: Tenderness at the site of injection (as with all injections). Flushing of the face which may last 2–3 days. In 1–2% a dull headache may occur as a result of dural puncture which will respond to lying down, drinking plenty of fluids and the usual pain killers. Should this occur please contact me at the numbers below. Most headaches will resolve spontaneously. Rarely a blood patch may be required. As with all injections, infection may occur but this is rare …
>
> **After injection**: … If you have any concerns, contact me on [cell phone number] or ring [the private hospital].
>
> Email me two weeks after the injection — [email address] with your progress …"

35. Dr B asked Mrs A whether she wanted to proceed with the epidural steroid injection. He recorded in the notes that he explained that he could not predict the benefits of the injection. He also recorded in the notes that "patient decided that she would like to proceed to see the benefits it might bring", and he believed it was worthwhile trying the injection given the lack of other options available. Mrs A told HDC that she had been considering the procedure for four years, and decided to go ahead with it. Nonetheless, due to the lengthy consultation and Dr B's conduct, she felt that she was under duress. She said that she was also partly persuaded by Dr B repeatedly telling her that he was "the best at doing [epidural injections]", having done "about 40,000 procedures".

36. Mrs A stated that Dr B did not inform her that the risks of serious complications were potentially greater because of the complex nature of her spinal history and her presenting condition. Mrs A's support person confirmed that Dr B explained the risks and benefits of the procedure. In her opinion, the standard risks and benefits were discussed, and nothing apparent was left out. She does not recall whether Dr B informed Mrs A that her history and presenting condition meant that the risks of serious complications were potentially greater.

Epidural injection

37. In the procedure room, Mrs A lay on her side and loosened her belt. She told HDC that Dr B, without asking, pulled down her trousers in a rough manner to expose more of her back, and that she was exposed down to her mid thigh. She felt extremely vulnerable, despite her support person being present. In response to the provisional opinion, Dr B said that Mrs A was wearing tight fitting jeans, and he asked her to loosen them before lying on her side. Dr B said that he made the final adjustment to her trousers to allow for adequate exposure of her back.

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38. Mrs A's support person asked Dr B for a blanket to cover Mrs A. Dr B said that the sterile drape would cover her, but he took around five minutes to prepare for the injection. Mrs A stated that during that time she was "quite tearful, cold and exposed". Dr B did not have an assistant present.

39. In response to the provisional opinion, Dr B said:

> "I call on an assistant if I feel I need one but [Mrs A] had a support person and I was happy for her to be present. We are a hospital and have plenty of staff to call upon if needed and I often do especially the elderly and patients who have difficulty in mobilising and anxious patients who do not have a support person [sic]."

40. Dr B informed HDC that his sterile procedure involves using disposable prepacked trays, gloves, and a no-touch technique. He does not wear a gown or mask, and has not done so for 45 years.

41. Dr B went ahead with the procedure using a 22g spinal needle. The clinical records note: "Epidural at L4/5 level 22 spinal needle [triamcinolone] 80mg in 10 mls saline." Dr B did not record the method used to identify the epidural space or loss of resistance, or whether there was any paraesthesia[10] or cerebrospinal fluid backflow during the needle placement. Mrs A said that as the needle was being inserted she heard Dr B mutter, "It's narrow, it's a bit tight." She did not find this comment reassuring.

42. In response to the provisional opinion, Dr B said that he always uses air to define the loss of resistance and not saline, so as not to confuse it with cerebrospinal fluid. He also said that if the procedure is uneventful, he will record it as such, but if he has difficulties with access or if there is a dural puncture, he will document it.

43. After the procedure, Dr B made a follow-up appointment for 15 May. Mrs A and her support person then left.

Events following the appointment

44. Dr B had told Mrs A that, after the injection, she might feel some discomfort, so she should rest. However, Mrs A told HDC that by the following day she had experienced a 300% increase in pain. She had severe pain in her head, lower back, and leg, and she also experienced photophobia (extreme sensitivity to light), irritability, nausea, tinnitus (ringing in the ears) and shock due to meningeal irritation (irritation of the membrane covering the spinal cord).

45. On 24 April 2012, Mrs A arranged an urgent appointment with Dr C. He advised bed rest and prescribed Sevredol for pain relief. However, Mrs A experienced side effects and instead had to use nortriptyline and paracetamol. On 9 May 2012, she saw Dr C again complaining of lower back pain, left leg pain, and increasing headaches and discomfort following the epidural steroid injection. Dr C recorded in his letter to Mrs

[10] See footnote 3 above.

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A's physiotherapist that his impression was that Mrs A had meningeal irritation following the lumbar puncture.

46. On 10 May 2012, Mrs A sent an email to Dr B cancelling her follow-up appointment. She described her physical reaction and pain levels after the procedure, and explained that she was seeing Dr C. Dr B told HDC that he did not receive this email. He said that his information sheet instructs patients to call him if they have any concerns.

47. Dr C spoke with Dr B on or about 17 May, and they discussed the possible treatment options of a blood patch or bed rest. Dr B does not recall speaking with Dr C on that date, but told HDC that he may have done so. Mrs A chose to treat her symptoms with bed rest. In response to the provisional opinion, Mrs A said that she did not want to have any further direct contact with Dr B, because she had been "significantly traumatised by his professional practice". Mrs A experienced pain for more than three months following the procedure and continues to suffer with headaches.

Changes to practice

48. Dr B has reviewed the Australian and New Zealand College of Anaesthetists (ANZCA) Guidelines PS03 (2013) and PS28 (2013). He has told HDC that since receiving the provisional opinion, he has changed his practice to meet the ANZCA Guidelines and is performing epidural steroid injection procedures in accordance with those guidelines. Dr B has advised that, in accordance with the Guidelines, he now wears a gown and mask and will only perform epidural steroid injection procedures at clinics where an assistant is available.

49. Dr B has provided HDC with a written apology for forwarding to Mrs A.

Responses to the provisional opinion

50. Responses to the provisional opinion were received from Dr B and Mrs A, and have been incorporated into the "information gathered" section where relevant.

Relevant standards

51. The ANZCA provides professional documents that define ANZCA's requirements for training, provide guidance to the College's trainees and Fellows on standards of anaesthetic practice, and define the College's policies.

52. Relevant ANZCA standards for an epidural steroid injection are:

PS03 Guidelines for the Management of Major Regional Analgesia (2011)

"2.4 Initiation of major regional analgesia requires appropriate assistance …

2.6 Infection control measures to be followed, including the use of a sterile field, facemask, gloves and gowns where appropriate, are stated in *PS28 Guidelines in Infection Control in Anaesthesia*. Skin preparation should be

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conducted in such a manner that agents used for skin preparation are unable to contaminate drugs or equipment used for neural blockade."

PS28 Guidelines on Infection Control in Anaesthesia (2005)

"3.1.3 Regional Anaesthesia

… When a spinal or epidural block is being performed … full aseptic technique including the wearing of facemask, sterile gown and gloves, and the use of a sterile field bordered by sterile drapes is required."

The following Faculty of Pain Medicine, ANZCA standard is also relevant:

"PM3 Lumbar Epidural Administration of Corticosteroids

… 3.5 Patients should be clinically reviewed after ESI with respect to pain relief, neurological function and side effects. Patients should be instructed to report back if they experience any new symptoms."

Cole's Medical Practice in New Zealand, published by the Medical Council of New Zealand, provides guidance on professional boundaries in the practice of medicine. The 2011 version was relevant at the time of these events, and includes the following passages at pages 36–37:

"**Respect** is necessary in an effective doctor patient relationship. Doctors working in New Zealand will meet patients who have different values and priorities from their own …

Trust is essential between a doctor and patient. A patient who needs to reveal him or herself intimately physically and emotionally to a doctor feels vulnerable. Doctors need to feel safe too. The best protection for both is healthy professional boundaries.

Ways of maintaining professional boundaries include: …

- The doctor keeping his or her own personal problems private."

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Opinion: Dr B

Assessment by Dr B — Breach

53. Mrs A was referred to Dr B for consideration of an epidural steroid injection. At the time of Mrs A's consultation with Dr B on 23 April 2012, Dr B had received a brief referral note from Dr C, but Dr B had not received the detailed referral letter he was expecting.

54. Dr C's referral note recorded that Mrs A had left leg radicular symptoms, and that her MRI had confirmed disc bulges with foraminal narrowing. Dr B asked Mrs A about her medical history, reviewed her MRI scan, and examined her. Dr B told HDC that in particular he examined Mrs A's posture, how she stood, the tenderness of her spine, and her range of movements, and looked for any evidence of nerve root irritation. He said he also examined the scar on her back from her spinal fusion surgery.

55. My expert advisor, anaesthetist Dr David Jones, advised that a pain management specialist needs to take a detailed history about the patient, and his or her pain experiences, lifestyle, and past medical history. Dr Jones described Dr B's examination as "cursory". While a physical examination was relevant, a proper sensory examination was the more important aspect that should have been checked in determining whether an epidural steroid injection was indicated. Such testing would, at a minimum, include examination of the sensory system (such as light touch or sharp pricking), deep tendon reflexes and power in the lower limbs, and a straight leg raise manoeuvre.

56. Dr B told HDC that he did not conduct sensory tests of light touch or pin prick because Mrs A gave no history of impaired sensation or allodynia. Dr Jones advised that Dr B's reasons for not conducting a sensory examination were at odds with the symptoms documented by Dr C. Although I note that Dr C's report documenting those symptoms was not available to Dr B at the time of his consultation with Mrs A, Dr Jones advised that it is information that Dr B should have elicited from Mrs A during his consultation with her. In addition, as noted by Dr Jones, Dr B did identify that Mrs A had a sensory abnormality, in that he documented that she was "very tender to pressure over L3 and S1".

57. Dr Jones notes that before evaluating whether the epidural steroid injection was appropriate and indicated for Mrs A, Dr B should have ensured that he had a full understanding of the clinical characteristics of Mrs A's pain. It does not appear that he did so, as there is no evidence that Dr B gave adequate consideration to Mrs A's history and symptoms, and he did not conduct the necessary sensory examinations. In my view, Dr B's failure to conduct a full examination, including an examination of Mrs A's sensory system, was a moderate departure from the accepted standard, and a breach of Right 4(1) of the Code.

Informed consent — No breach

58. Before a consumer can make an informed choice and give informed consent to a proposed procedure, the consumer must first be informed of the risks and benefits of that procedure. Dr B told HDC that he gave Mrs A a lengthy explanation about the

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procedure, including that it is of less benefit for mechanical back pain and that it is less effective after major back surgery. He provided Mrs A with an information sheet, and he recorded in the notes that he explained that he could not predict the benefits, but that he believed it was worthwhile trying the procedure given the lack of other options available.

59. Mrs A accepts that there was a discussion about the risks and benefits of the procedure. However, she complained that she was not informed that the risks of serious complications were potentially greater because of the complex nature of her spinal history, and her presenting condition.

60. Mrs A's support person has confirmed that Dr B discussed with Mrs A the risks and benefits of the procedure. In her opinion, the standard risks and benefits were discussed, and nothing apparent was left out. She does not recall whether Dr B informed Mrs A that her history and presenting condition meant that the risks of serious complications were potentially greater.

61. All the parties present at the consultation agree that there was a discussion about the risks and benefits of the procedure. In these circumstances, there is insufficient evidence that Mrs A was not adequately informed and thus unable to give her informed consent to the procedure. In addition, although Mrs A said that she felt she was under duress given the lengthy consultation and Dr B's manner, there is no evidence that Dr B placed any pressure on Mrs A to have the procedure such that Mrs A was under duress to proceed.

Treatment procedure, sterility techniques, and documentation — Breach

Assistant and sterile precautions

62. Dr B did not have an assistant present during Mrs A's procedure on 23 April 2012. In response to the provisional opinion, Dr B said that he did not feel that he needed an assistant in this case because Mrs A had a support person present.

63. ANZCA PS03 Guidelines for the Management of Major Regional Analgesia (2011) (the PS03 Guidelines) state at 2.4 that "initiation of major regional analgesia requires appropriate assistance". Dr Jones advised that an epidural steroid injection is a major regional analgesia, and therefore an assistant should have been present to assist with:

> "accurate patient positioning, helping move modesty sheets, contribute to and check of drawing up sterile injectate from ampoules …, encouragement during the 'touchy' moments of the procedure …, monitor the patient with such as [blood pressure], and assist or summons help in the rare case of an emergency".

64. Dr B informed HDC that his sterile procedure involves disposable prepacked trays, gloves, and a no-touch technique. At the time of these events, he did not wear a gown or mask when performing epidural steroid injections.

65. The ANZCA PS03 Guidelines and the PS28 Guidelines on Infection Control in Anaesthesia (2005) both highlight the need to take proper sterile precautions when performing this procedure. Dr Jones advised me that the ANZCA recommendations

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"describe a standard for best practice in Australia and New Zealand", and Dr B failed to meet these standards in this case.

66. Dr B's failure to take adequate sterile precautions and to have an assistant present did not comply with professional standards and, accordingly, I find that Dr B breached Right 4(2) of the Code.

Documentation

67. Failure to maintain an adequate clinical record is, in itself, a breach of professional standards. The MCNZ Guideline "The maintenance and retention of patient records" (August 2008) provides that the clinical record should note the relevant clinical findings, decisions made, information given to patients, and any drugs or other treatment prescribed. Furthermore, this Office has frequently emphasised the importance of record-keeping.[11]

68. Dr B failed to document his identification of the epidural space or loss of resistance, or whether there was any paraesthesia or fluid backflow during the needle placement. This is information that should have been recorded, and his failure to do so was a breach of professional standards and, accordingly, a breach of Right 4(2) of the Code.

Professional conduct — Breach

69. During the consultation, Dr B told Mrs A and her support person about his own health condition, and spent time discussing the details of it. Mrs A told HDC that she felt that Dr B minimised her experience.

70. Dr B told HDC that he shares details of his health condition with patients not to demonstrate pain, but rather to help people to understand their condition and to illustrate how they can manage to cope and lead a reasonably functional life. He also said that mentioning his own health was an attempt to be empathetic, and not to minimise Mrs A's condition.

71. I agree with Dr Jones that there does not appear to be any aspect of Mrs A's assessment or care that was enhanced by Dr B introducing his own health concerns into the consultation. Although I appreciate that in doing so he intended to assist Mrs A to better understand her condition, in these circumstances it had the effect of making Mrs A feel that Dr B was minimising and devaluing her experience.

72. *Cole's Medical Practice in New Zealand* (2011) states that "the doctor keeping his or her own personal problems private" is one way of maintaining professional boundaries.

73. In the circumstances of Mrs A's consultation with Dr B, I consider that Dr B's actions in introducing his own health condition into the consultation breached professional boundaries. Accordingly, I find that Dr B breached Right 4(2) of the Code in this respect.

[11] See Opinions 10HDC00610 and 10HDC00509 (available from ww.hdc.org.nz).

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Recommendations

74. I recommend that Dr B:

- review his practice in light of my expert's comments, and study the ANZCA and Faculty of Pain Medicine professional documents referenced in this report, and report back to me on his learning by **15 January 2014**; and
- provide me with a progress report, including examples, on all changes made to his practice following this complaint, and the recommended learning, by **15 January 2014**.

75. I also recommend that the Medical Council of New Zealand conduct a review of Dr B's competence and conduct.

Follow-up actions

76.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Medical Council of New Zealand and the District Health Board, and they will be advised of Dr B's name.

- 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 New Zealand Society of Anaesthetists, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from anaesthetist Dr David Jones:

"… **I have read and agree** to follow the Health and Disability Commissioner's guidelines for independent advisers (my copy dated 5 March 2007).

I qualified Fellow of Faculty of Anaesthetists, Royal Australasian College of Surgeons (FFARACS) in 1980, admitted as Fellow of Australian and New Zealand College of Anaesthetists (FANZCA) in 1992 and admitted as Foundation Fellow Faculty of Pain Medicine (FFPM ANZCA) in 1999. I have practiced at Dunedin Hospital / University of Otago as a specialist in anaesthesia and pain medicine since 1983. I have extensive and ongoing experience consulting with, examining and managing patients with similar presentation to your case in question.

I have no conflicts of interest to declare in relation to this case and enquiry. I do know of the practitioner concerned but have no recollection of meeting him.

I have reviewed material supplied by you:

1. Letter of [Mrs A] addressed 'To whom it may concern' dated 23 July 2012.

2. Five letters from [Dr C] (of [company] addressed to [physiotherapist] dated: 27 March, 24 April, 9 May, 19 June, 31 July 2012.

3. Referral letter from [Dr C] to [Dr B] dated 27 March 2012, comprising 3 sentences of clinical information and noted a prior 4 Level fusion 10 years earlier. This copy was submitted to this investigation by [Dr B].

4. Letter from [Dr C] to [the Health and Disability Commissioner] dated 26 Sept 2012 (overview of [Mrs A's] case).

5. A single page, undated, incomplete part of a report, signed by [Dr C], copied to [an] (ACC Case Manager) and patient, commences 'There is reduced power and sensation ...'. I cannot discern whether any important history is concealed in the missing part, or whether the omission of the rest is simple error. The utility of the information in this page is its detail of physical findings and plain radiology done at an unknown time but clearly prior to MRI and referral for Epidural Steroid Injection (ESI).

6. Report by [Dr B] dated 27.03.2012 'History / Assessment', with sections 'Clinical Assessment', 'Treatment', 'Recovery' and 'Follow up'.

7. Letter by [Dr B] to [Health & Disability Commissioner] dated 12 Oct 2012.

8. [Dr B's] information sheet 'Therapeutic Epidural Injection', which included 4 means of contacting him (email, fax, SMS, Mobile).

9. MRI report by Dr […] to [Dr C], dated 8 Mar 2012.

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Summary of Opinion:

1. There were likely organisational aspects of [Dr B's] practice that lead to not having patient information available when [Mrs A] attended. [MILD]

2. A trusting patient–doctor relationship was not made — starting from the poor first impression made due to the above. [MODERATE]

3. [Dr B] did make his own assessment of her, rather than do the procedure requested without question. [POSITIVE]

4. Only a very cursory physical examination was performed, and no sensory examination is reported by either party. [MODERATE]

5. It appears he did discuss some other things she might do as well as or alternative to the epidural injection to help manage with her problem. [POSITIVE]

6. Neither party's account indicates, in relation to informed consent, that she would have been appraised that with her clinical situation there was a very low likelihood of benefit, nor the fact that she came with increased risks of complications due to prior surgery. [MILD]

7. There is some doubt about completeness of sterility procedures, compromised by lack of any assistant. While it did not meet ANZCA recommended standards, it appears to have been performed the way many practitioners have done them in the past. [MILD]

8. Although undetected at the time, a significant complication followed, for which [Dr B] appears to have had no significant availability for advising or managing it, until 24 days later through contact by the patient's GP. [MODERATE]

9. Unprofessional boundary breaches occurred by introduction of [Dr B's] own personal health problems into the consultation [SEVERE], aggravated by using them to minimise the patient's problem through comparison [SEVERE], plus lack of respect for the patient's lack of knowledge of, nor interest in [the matters relevant to his health condition] [MODERATE].

10. One of those matters (ie [Dr B] showing and discussing [aspects of his health condition]) also indicated a lack of professional specialist knowledge about [pain experiences] [MODERATE].

11. [Information redacted as not relevant to matters under investigation.]

12. Details and explanations for opinion follow.

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I Standard of Care

A. Assessment

1. The referral letter (item 3 of material referred to) contained negligible detail about [Mrs A's] condition (3 sentences): it mentioned prior spinal surgery, relevant spinal levels for that, and the duration since it was performed.

2. To [Dr B's] credit, he did not proceed straight to doing the Epidural Steroid Injection as requested without making his own assessment. A pain management specialist needs to take **a detailed history** about the patient, their pain experiences and what they do in their life, in addition to past medical history etc. This was especially so in this case where there was little in the referral letter. [Mrs A's] letter indicates [Dr B] did ask further questions ['[Dr B] proceeded to ask me questions about my surgical and medical history'].

3. Neither party's material submitted to this review discloses enough to conclude whether the history part of the assessment was done to a good standard.

4. **Physical Examination**: The narrative of [Mrs A] and report by [Dr B] indicate this was cursory. The focus seems to have been on her mechanical range of movement — where one would expect it to be limited due to past surgery. It is relevant in part to determining if there are any contraindications for epidural injection, eg available intervertebral spaces, or by inspection to exclude local infection.

5. However, the sensory element of pain is a nervous system function, and a proper sensory examination is by far the more important aspect to understanding what processes might be involved in the pain condition.

6. This would have required examination with stimuli of sharp pricking and light touch/brushing type as a minimum, but for completeness could include thermal, vibration and position senses as well. Deep tendon reflexes (at least in the lower limbs as relevant to this case) should be assessed.

7. Neither party's information indicates any of these were performed, nor does the referral letter include that detail [ie not available from alternative source]. [MILD]

8. [Dr B] did report that [Mrs A] was 'very tender to pressure over L3 to S1' which indicates one type of sensory abnormality [allodynia, or sensitivity to light pressure stimuli which normally would not be painful].

9. If the appropriate sensory testing referred to in (6) above had been carried out, [Dr B] should have known whether the abnormal sensitivity finding was confined to the posterior portion of the back, or alternatively was down the limb in the distribution of the nerve intended to be treated. This would have informed a distinction between (a) truly radicular pain or (b) neuropathic pain from other superficial skin nerves disturbed during prior surgery. Epidural steroid injection is indicated for (a) but not (b).

10. I cannot tell from either party's report if [Dr B] actually examined the MRI images, or only the radiologist report of same. However the radiologist and [Dr B's] reports both use consistent terminology: '*minor left sided broad based disc*

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bulges ... no evidence for nerve root compromise' in the one, correlating with '*Minimal bulging ... with no nerve root compression'* in the other's report.

11. I cannot reconcile [Mrs A's] statement (page 2, para 2), which she attributed to [Dr C] whom she calls her 'referring specialist', regarding 'under-reporting' of her MRI. That would seem like trying to make it fit some preconceived condition.

12. I am puzzled about her reference to 'referring specialist' here. [Dr C's] vocational specialty is sports medicine, and all his letters are on [sports medicine] letterheads. However none of [Mrs A's] problem has anything to do with sports or sports medicine. That is not however criticism of his care of her (see later). I assessed his involvement as being what I would expect of a GP.

13. MRIs of normal people without any back pain frequently show disc 'bulges', which differ considerably from a disc extrusion with nerve root compromise and foraminal stenosis (= a tight exit hole for the nerve roots). In addition the MRI report indicates maintenance of disc quality at all lumbar levels (MRI report: '... *no evidence for desiccation or degeneration.'*)

14. [Dr B's] report [item 6] does not reassure me that he had a full understanding of the clinical characteristics of this patient's pain, a necessary precursor to evaluating whether the treatment requested by [Dr C] was indicated. It is possible that components of a pain history relevant to assessing that were done to an adequate standard, but detail omitted from the written report. The closest the assessment gets is '... mainly mechanical low back instability with a suggestion of left L5/S1 radiculopathy'. ESI is not a treatment for mechanical instability.

15. Armed with this information: there are no clear radicular signs from sensory testing nor any tendon reflex changes recorded, negative MRI findings with no nerve root compromise, very longstanding pain as an *original* problem rather than a new one, with prior major lumbar surgery which increases the difficulties and risk from attempting an ESI, then in my opinion there was a very low chance of it helping. This becomes especially relevant to assessing the informed consent quality.

B. Informed consent

1. [Mrs A] stated in her letter to you: '[Dr B] broadly explained the risks and benefits of the proposed epidural'. [Dr B's] written information sheet about the procedure [item 8] is of an adequate standard.

2. I cannot discern how long beforehand she received the written information sheet. Her descriptions of being 'under duress' are retrospective, so it is difficult to ascertain exactly how she and her supporter were questioning or interacting at the time on what was important *to her specifically* to decide to accept or decline.

3. As she stated she had been deliberating for some time (4 years) as to whether she would accept one, we might presume she had some knowledge already, and could have been in a better position to pose deeper searching questions than had this been sprung on her unexpectedly.

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4. [Mrs A's] letter indicates [Dr B] did appropriately make reference to other treatment modalities, even though she indicated she did not like what she thought he meant.

5. I could not detect anything from the reports that suggested any coercion by [Dr B] for her to have the procedure. The reports of [Mrs A] give the strong impression he was suggesting there was not much wrong with her (see section on professionalism), so why would she need this procedure anyway (ie in the other direction)?

6. Although we could laud a user-led decision on acceptance or not of this procedure, and recognising the likelihood of it helping was low and the risk of complications higher due to prior surgery, in my opinion it would have been better for [Dr B] not to have proceeded with it *at that time* especially after trying to give her an impression there was not much wrong with her! The two are contradictory.

7. [Mrs A] also indicates she is a [health care professional], and displayed in her letter quite a lot of insight into the nature of these processes (eg format of modern MRIs on discs). Even though the onus is on the practitioner to inform fully, and not assume that because she had some extra knowledge she would not need the normal information, in the end the patient did accept the procedure. Although I consider she did not have the correct indications for ESI, many practitioners would have proceeded and justify that on the grounds that *correctly carried out* the risks of doing harm are not normally excessive. Although not demonstrably of a high standard, I cannot advise you that the informed consent standard was seriously deficient.

C. Treatment Procedure

1. The positioning of patient for the procedure was normal. Unfortunately to get proper sterile preparation of skin and draping it is necessary to expose down to the upper buttocks. [Mrs A's] description of feeling exposed is in accord with that. When an assistant is present, a light sheet can be left covering the patient until the moment of applying skin sterilisation paint. She had a supporter there, but apparently no trained assistant.

2. Patient feeling cold does not have a neat remedy in this procedure, apart from working in a warm room! There will still be the 'cold shock' when alcohol containing skin sterilisation solution is applied!

3. [Mrs A's] statement does not mention any assistant for [Dr B]. I would not accept her support person as an adequate substitute for a trained assistant for the following requirements while performing epidural procedures: accurate patient positioning, helping move modesty sheets, contribute to and check of drawing up sterile injectate from ampoules (triancinolone and local anaesthetic for skin do not come in presterilised ampoules, so care is needed to maintain a sterile work surface), encouragement during the 'touchy' moments of the procedure — as it would be rare not to have at least some discomfort during parts of it, monitor the patient with such as BP, and assist or summons help in the rare case of an emergency. [MILD].

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4. ANZCA's professional documents describing standards for this procedure:

1. PS03 Guidelines for the Management of Major Regional Analgesia[1]

2.4 Initiation of major regional analgesia requires appropriate assistance.

2.6 Infection control measures to be followed, including the use of a sterile field, facemask, gloves and gowns where appropriate

PS28 Guidelines on Infection Control in Anaesthesia[2]

3.1.3 Regional Anaesthesia … full aseptic technique including … facemask, sterile gown and gloves

ESI requires the same sterile precautions as other major regional anaesthesia.

5. The lack of an assistant does make me wonder at the quality of the sterile technique during this procedure — I could not myself maintain a complete sterile setup for this procedure without same.

6. There is no positive indication in [Mrs A's] report of gown/mask being used, and [Dr B's] record is silent on this. Although ANZCA recommends full sterile gown/gloves/mask, there has been an older cohort of practitioners who only used sterile gloves, which was a former minimalist standard which used to be accepted. You may consider asking [Mrs A's] support person what she saw to clarify that.

7. There is only indirect indication in [Mrs A's] account that a sterile drape was to be used ([Dr B] told her it would cover her). I am surprised she does not mention the above described cold shock from skin sterilising paint solution — therefore I cannot tell whether it was done or not.

8. [Dr B's] comments reported by [Mrs A] during the procedure are commonly heard (and usually accurate from the operator's perspective, because some spaces really are narrow, calcified and hard, or 'tight' as she heard). I would not assess them to indicate per se any lack of care or skill in performing the procedure. [Mrs A] reminds us how un-reassuring such comments are to the receiving person!

9. Deficiencies in this procedure as recorded, measured against ANZCA standards, include questionable sterile technique, lack of trained assistant, failure to record the method of identifying epidural space/loss of resistance (LOR)[3] and whether there was any paraesthesia or CSF backflow during the needle placement. [MODERATE]

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[1] http://www.anzca.edu.au/resources/professional-documents/documents/professionalstandards/professional-standards-3.html

[2] http://www.anzca.edu.au/resources/professional-documents/documents/professionalstandards/professional-standards-28.html

[3] I note [Dr B] used an old method for Epidural injection — namely a 22g Spinal needle. Although I was also first trained to use that method, I would not like to revert to it! A modern Tuohy needle and saline LOR technique lessens the risk considerably of making a dural puncture, with subsequent inadvertent intrathecal injection of the steroid mixture. It has a more reliable endpoint to identify the epidural space.

10. **Follow-up:** despite [Dr B's] appropriate provision of contact numbers, when faced with significant severe after-effects [Mrs A] reported she was unable to make any of the contacts work. No deputising service was made known to her, if there was one. [MODERATE]

11. The Faculty of Pain Medicine, ANZCA Professional Document PM3: Lumbar Epidural Injection of Corticosteroids (2010)[4], recommends follow-up, which should be by the proceduralist unless an alternative appropriately trained person is delegated it:

'3.5 Patients should be clinically reviewed after ESI with respect to pain relief, neurological function and side effects. Patients should be instructed to report back if they experience any new symptoms.'

12. [Dr B] did not review her, and as far as the material here indicates, did not hand her back to an appropriately trained alternative [MODERATE]. As [Dr C] is a sports medicine doctor, I would not consider he was the appropriate substitute for assessing the complications of the ESI here. It is noteworthy however that he gave much needed support to [Mrs A], and soldiered on for a long time in a very difficult situation for them both, and did get back to [Dr B] later.

13. It was not until an interval from the procedure (23 April) until around 17 May had passed that a blood patch was recommended by [Dr B] via a telephone request by [Dr C].

14. However given the spectrum of symptoms she developed, I think it much more likely that a chemical meningeal irritative complication arose, in contrast to just a dural puncture headache, most likely from inadvertent intrathecal injection of the steroid. Therefore the recommended blood patch was not the appropriate treatment.

II. Appropriateness of [Dr B's] manner

A Greeting, Rapport and Empathy

1. [Dr B's] not having available the appropriate referral letter with the reason for her attendance reflects a lack of practice organisation on this occasion. I could not discern if he had secretarial help (he typed his own report in the consultation). [MILD]

2. I cannot establish from the records exactly how the referral was made, and whether [Dr B] had received the referral letter from [Dr C] dated 27 March in advance. [Mrs A] stated she handed it to [Dr B], but it is not clear whether that was the first time he had seen it, or a copy of same. IF it was the first time he had seen it, then that is poor methodology for a referral process, reflecting on all the professional parties to this transaction. [MILD]

3. Even if he did have that letter, it contained only 3 sentences, so would not have been informative enough. [Dr B] did however cover that deficiency as described in section I A (2) above.

[4] http://www.fpm.anzca.edu.au/resources/professional-documents/documents/PM%203%20May10.pdf

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4. His irritation over lack of the referral letter seems to have conveyed a poor first impression to the patient. First impressions count for a lot! The tone in which he (is reputed to have) asked [Mrs A] the questions 'Now who are you, and why are you here' (page 1, para 4, lines 1–2) could be more important that the actual questions themselves, which superficially ask 2 reasonable questions. I cannot gauge the tone from the material. [MODERATE]

5. I would like to assume she answered those questions with her name at least, but then she implies he failed to recognise her *vis-à-vis* prior ('at length') phone conversations. I would have expected at that point some triggering of a memory/recognition of these conversations given the relatively short interval (up to 1 month).

6. Cumulatively these things triggered a poor rapport and start to this consultation. Although not widely acknowledged there is growing realisation from research that in managing chronic pain the therapist–patient relationship may play as big if not more important role in patient outcome than a particular physical/biological treatment. This is at least one learning message for [Dr B].

7. Empathy — see below.

B Professionalism
Several concerning unprofessional behaviours are examined in this section:

1. [Information redacted as not relevant to the matters under investigation.] Much more concerning was displaying and discussion his own [health condition].

2. [Information redacted as not relevant to matters under investigation.]

3. The medical profession has been made aware for as long as I can recall of the need for boundaries in practice. The MCNZ has regularly brought this to our attention, and recommends plus publishes Cole's Medical Practice in NZ (current version is 2011) as a reference guide.

4. The section relevant to this case (page 37, text reproduced as Appendix I) lists ways of maintaining professional boundaries, including 'the doctor keeping his or her own personal problems private'.

5. [Dr B] breached this boundary in a very unprofessional manner if [Mrs A's] report is accurate. [SEVERE]

6. If he had done so in an empathic sense, such as empathising with her problem if his own experiences were similar, even though that would be technically a breach it may not have had such a negative impact on this consultation.

7. However an **aggravatory feature** of his breach was to use his case in the sense of minimising her plight, by implying he was worse (anti-empathic). [SEVERE]

8. IF [Dr B] did say he would show her 'what real bulging and real pain looked like' ([Mrs A's] statement, page 1, last para — and assuming she accurately quotes him there) — then I must assert it reflects a lack of professional knowledge a pain specialist must have — namely that you cannot see pain on X-rays. Studies using post mortem material have shown there is no correlation between the

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severity of spinal pathology (which might also be visible on X-ray) and lifetime reports of the degree of any pain experienced. Many people with disc bulges have no pain, so his comments are inappropriate. [MODERATE]

9. I note that despite [Mrs A's] letter making this breach so obvious, [Dr B's] response to [the Health and Disability Commissioner] still does not recognise his breach as he goes on to give another irrelevant and embittered paragraph about his own health problems and dissatisfactions with ACC. They really had no place in this matter at all.

10. Another breach of professionalism relates to **[Dr B's] [personal interests] being introduced into the consultation**. I can see no justification for even raising that subject in a patient consultation. In a user-led atmosphere IF there was a *shared* interest between the patient and the professional, then I would not criticise this as it may add to rapport, provided it did not distract from the task in hand and the third party payer was not billed for the time it took! WHEN the patient says they were not interested, that line of discussion should have ceased. It did not. If being 'affronted' is an accurate description of what transpired, I would suggest that was a form of intimidation/belittling of this patient or alternatively a lack of respect for her different values and interests (Appendix II). [MODERATE]

III. Possible remedial measures

1. [Information redacted as not relevant to the matters under investigation.]

2. The above is based on my clinical suspicion that an inadvertent intrathecal injection of the steroid occurred, rather than the intended epidural one. In that regard, please note:

a. The records here do not indicate this risk was fully appreciated by [Dr B], who also does not describe any precautions he took to try and detect whether or not he was in the correct place (no description of loss of resistance method, nor mention of a check if there was any CSF flow ... which should then have led to abandoning the procedure rather than injection of steroid).

b. Fully competent operators could also make an inadvertent intrathecal injection even when taking full care, so that needs to be taken into account such that the above recommendation is only to check if there are health issues in addition to normal risks for such procedures.

c. [Mrs A] uses terminology in her complaint indicating desire to attain treatment injury status with ACC. As I have not assessed her in person, this report should be not be used for that purpose.

3. For the three areas of breaches of the professionalism required by MCNZ of all doctors practicing in NZ and described in accessible recommended publications:

a. Discussing (at some length) own health problems with patient (**boundaries**)

b. Aggravated by using that in a manner which belittled this patient's problem

c. **Lack of respect** by discussing his [personal interests] with a non-interested patient it is a decision for the Commissioner whether that breaches the Code of

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Health and Disability Services Consumer Rights, and whether that should be referred on for further consideration.

4. You could consider including a recommendation that [Dr B] as part of his Continuing Professional Development include study of the ANZCA and Faculty of Pain Medicine professional documents referenced in this report relating to standards of practice for this procedure and area of practice.

5. [Mrs A's] request for an apology seems reasonable at least in respect of there having been a significant complication/unintended consequence, the unprofessional matters referred to above which were introduced into the consultation, and not making a more specific follow-up plan for her complication following his procedure.

Signed:
David Jones FANZCA FFPMANZCA 16 Feb 2013

Appendix I:
Extract from Cole's Medical Practice, 2011, Page 37:
Trust is essential between a doctor and patient. A patient who **needs to reveal** him or herself intimately physically and **emotionally to a doctor feels vulnerable**. Doctors need to feel safe too. The best protection for both is **healthy professional boundaries**.

Ways of maintaining professional boundaries include:

- asking only relevant personal details when taking a medical history;
- explaining sensitive examinations or treatment before carrying them out;
- keeping discussions and records confidential;
- providing privacy with screens for undressing, draping or dressing;
- checking if the patient wants a chaperone present or support person, and sometimes asking the patient to allow someone at the doctor's request;
- avoiding words, actions or jokes that are sexually demeaning or are embarrassing;
- **the doctor keeping his or her own personal problems private**.

Appendix II:
Extract from Cole's Medical Practice, 2011, Page 36:

'**Respect** is necessary in an effective doctor patient relationship. Doctors working in New Zealand will meet patients who have **different values and priorities** from their own.'

Appendix III:
Health concerns

Under section 45 of the Health Practitioners Competence Assurance Act 2003 (HPCAA), doctors and their employers must advise the appropriate Council if they have reason to believe that a doctor or other health professional has a mental

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or physical condition that is affecting performance. (*... although this item is silent as to private self-employed practitioners*)"

Further expert advice was obtained from Dr Jones in light of additional information provided to HDC:

"… **I continue to have no conflicts of interest** in relation to this case.

I have read and agree to follow the Health and Disability Commissioner's guidelines for independent advisers (was not enclosed as stated in your letter. I have a copy dated 5 March 2007).

I have reviewed items below, 00001–00009 previously, plus additional items 00010-00015:

Number	Item	Dated
00001	Letter of [Mrs A] addressed 'To whom it may Concern' 6 pages	23 July 2012
00002	Five letters from [Dr C] (of [company]) addressed to [physiotherapist]	27 March 24 April 9 May 19 June 31 July 2012
00003	Referral letter from [Dr C] to [Dr B], comprising 3 sentences of clinical information and noted a prior 4 Level fusion 10 years earlier.	27 March 2012
00004	Letter from [Dr C] to [the Health and Disability Commissioner], an overview of [Mrs A's] case	26 Sept 2012
00005	Blank	
00006	Report by [Dr B]: 'History/Assessment', 'Clinical Assessment', Treatment', 'Recovery' and 'Follow up'	27 March 2012
00007	Letter by [Dr B] to [the Health & Disability Commissioner]	12 Oct 2012
00008	Information sheet 'Therapeutic Epidural Injection'. Includes means of contacting [Dr B] by email, fax, SMS, Mobile phone	
00009	[A] report of MRI on [Mrs A] by Dr […], addressed to [Dr C], copied to patient	7 Mar 2012
00010	Email from [Mrs A] to [Dr B]	10 May 2012
00011	Letter to [Dr B] from Anthony Hill,	

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	Health & Disability Commissioner	11 March 2013
00012	Response letter from [Dr B] to above	28 March 2013
00013	Letter to [Dr B] from … Investigator for H&DC	5 April 2013
00014	Response letter from [Dr B] to above	10 April 2013
00015	ACC Assessment and Treatment Plan from [Dr C] addressed to [physiotherapist]	29 Feb 2012

In response to your specific questions:

1. Adequacy of the physical examination performed By [Dr B] on [Mrs A]:

a. I have read my previous report regarding the examination (more specifically lack of same) and found nothing new in [Dr B's] letter [item 00006] which alters my previous assessment.

b. In summary, the only physical examination [Dr B] carried out was to get her to try [to] move her back/spine (correctly observed to be limited — as expected due to multiple level fusions), observe the extent of her surgical scar, and press around her back to conclude 'tenderness over L3–S1'.

c. At the very least examination of the sensory system, reflexes and power in the lower limbs should have been performed, as well as a straight leg raise manoeuvre (SLR) — especially as the proposal was that she might have 'radicular pain' (pain radiating down a limb due to nerve root irritation and which is demonstrably provoked/aggravated by carrying out an SLR).

d. [Dr B] states [00014 item 2] he did not carry out a sensory examination 'as she gave no history impaired sensation or allodynia'. This is at odds with [Dr C's] report [00015 para 4] of 'left leg pain with numbness and tingling into the foot and great toe'. [Dr B] did not have this report, so he needed to test sensation either to confirm it was normal (in the event she said there were no problems) or find abnormalities she either was unaware of or had reported if she gave [Dr B] the same history as is reported by [Dr C].

e. The failure to examine remains a **[MODERATE]** breach of standard of care.

2. Adequacy of sterile technique used by [Dr B]:

a. [Dr B's] description of his sterile technique is similar to what I recall many practitioners did in the distant past, although I do not recall any time not wearing a mask while preparing items for injections in or near the spinal canal and spinal fluid. I do recall an era when practitioners did not wear a gown, as is his description.

b. However with the benefit of constant review of outcomes and complications, and to assure sterility for something which if contaminated can lead to disastrous outcomes the ANZCA recommendations describe a standard for best practice in Australia and New Zealand. This remains as submitted in my earlier report.

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c. There have been recent case reports both in Australia & NZ and UK of very serious outcomes from contamination *even with* the full sterile technique, so these demand that practitioners do keep up with events like that and ensure their practices are risk averse.

d. [Dr B] asserts [00012 page 2 para 2] 'we do the same thing at [the public] Hospital' regarding not wearing gown and mask for epidurals. I can assure you that is incorrect, and the ANZCA standard has been applied there for well over 10 years.

e. I suggest [Dr B] be advised to adopt the ANZCA PS03 and PS28 standards, as submitted with my earlier report, for any future practice.

f. I note [Dr B's] qualifications are from [overseas], which does not cause me any concern. But if he submitted that because of that he does not have access to ANZCA recommendations/standards I would point out they are publicly available documents, which pertain to practice in our country and further there are prominent officers of ANZCA who are members of the anaesthesia department in [the public] hospital to which he refers in (d) above.

g. While on the subject of professional bodies [Dr B] belongs to, I note he refers to being 'a member of ANZSA'. I do not know such a body — he possibly is referring to the NZ Society of Anaesthetists (NZSA), which endorses ANZCA professional documents.

h. Despite the less than recommended standard in this case, it is not apparent to me that this caused the outcome [Mrs A] experienced.

i. I remain of the view expressed in the summary item 7 of my previous report that this is a **[MILD]** breach. There is potential for [Dr B] to lift his practice standard in this area to the current one practiced in our country.

3. Appropriateness of [Dr B's] decision to proceed with the epidural steroid injection:

a. A full detailed assessment and clinical report by [Dr C] [00015] leads me to conclude there was a possibility of L5–S1 radicular nerve irritation, and therefore an indication to *consider* Lumbar Steroid Epidural Injection (LSE).

b. A confounding detail from [Dr C's] examination is a '(Lt) oblique lumbar scar', which *could* alternatively [explain] her (Lt) sided pain. Neither party (ie [Dr C], [Dr B]) refers to any sensory testing in that location.

c. [Dr C] refers to motor power reduction, but no ankle jerk reflex abnormality, tending to point away from a radicular lesion.

d. As I read [Dr B's] responses he did not have the benefit of [Dr C's] information however, and it was also omitted in the prior material for me to assess.

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e. In the absence of that detail, [Dr B] should have elicited the same himself, but did not, this conclusion being based on lack of any record of it nor mention of it in his report.

f. Notwithstanding some indications and an un-noticed confounding factor, contra-indications and the degree of risk needed taking into account as well to balance any positive indications — especially in the face of previous spinal surgery/fusion. Then it comes down to patient acceptance (or not) of the risks against the benefits and their consent following full information and a recommendation.

g. In his report [00006], after an inadequate (or unrecorded) physical examination, [Dr B] argues against the usually accepted indication for ESI: 'Has mainly mechanical low back instability with a suggestion of left L5/S1 radiculopathy', having earlier noted, in agreement with the Radiology report [00009], 'only shows minimal bulging of the lumbar discs with no nerve root compression'.

h. Given the much higher risk due [to] prior surgery and distorted anatomy, NO knowledge of positive physical examination detail and only a low likelihood of benefiting in this case, I would have (even with the benefit of [Dr C's] assessment detail) advised against ESI but modified by the patient's views of that advice (noting she was a health professional and would most likely have seen epidurals carried out). And I would have deferred it in the situation [Dr B] was in without [Dr C's] details and having failed to elicit physical signs either way.

i. [Dr B's] responses to you [00014] state that his reason for not examining her sensory system was 'she gave no history impaired sensation or allodynia'. This contradicts what is in [Dr C's] assessment report (but accepting [Dr B] did not have it then). It is especially contradictory to [Dr B's] proposal to do an ESI as these are the very symptoms suggestive of radicular nerve root irritation which add up towards deciding whether there was an indication to perform ESI.

j. In summary, for the above reasons I consider the decision to proceed to ESI in this case, at that time, was unwise.

k. However I must advise you that I believe a good number of practitioners (not necessarily all pain medicine specialists) would also have proceeded with performing an ESI.

<u>4. The appropriateness of [Dr B's] use of his own health information in the consultation:</u>

a. The advice to the profession regarding maintaining boundaries is 'the doctor keeping his or her own personal problems private' (see previous report B. 4).

b. [Dr B] gave no recognition or acknowledgement of that in his responses [00012].

c. He submitted that [Mrs A] took his comments the wrong way. If he had not breached that professional boundary there would not have been anything for her to misinterpret.

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d. In my opinion he makes the situation even worse by going on at length and expanding on his personal health issues in his responses to you. None of that has any relevance to his duty of care to [Mrs A].

e. There does not appear to be any aspect of [Mrs A's] assessment, care, or even empathy for her predicament, that was enhanced by [Dr B] introducing his own health concerns into the consultation.

f. I consider that was a [**SEVERE]** breach of professional boundaries and standards.

g. In addition, whatever he says about [Mrs A's] X-rays, there is a fundamental piece of professional knowledge for pain specialists that he does not acknowledge — namely that you cannot see a person's pain experience on X-rays, and that there is no correlation between X-ray appearances and the extent of a person's pain experience. [Discussing his own health condition] in [a] manner [that reflected this belief] was inappropriate and demonstrates his lack of knowledge of this fundamental issue in assessment and managing chronic pain.

h. However [Dr B] is by no means alone in implying that the opposite is the case.

5. Regarding [Mrs A's] email to [Dr B]:

a. If [Dr B] had seen the email, what action would I expect him to have taken?

i. As the email was 2 weeks following the procedure, he then had notice of a late severe complication. There are more questions that should be asked to try and differentiate likely reasons.

ii. Expecting [Dr B] to be specialised in epidural injection matters, he should have recognised that meningeal irritation had occurred (and [Mrs A] refers to that also). But hers was described somewhat differently compared to a typical post dural puncture headache (something that was included in [Dr B's] information sheet and one of the risks for discussion when obtaining consent to any epidural injection).

iii. I perceived that there was a belief (likely from [Dr C]) that a dural puncture headache was responsible for ALL her problems then. If that was seriously considered the cause, then appropriate treatment approaches could have been conveyed to [Dr C] (eg had epidural blood patch been considered?). [Dr B's] information sheet [00008] did contain basic advice on managing that, as well as advice to contact him and let him know.

iv. However I think the picture given by [Mrs A] seems more likely related to a chemical irritation from inadvertent intrathecal (ie inside the spinal fluid sac) injection of the triamcinolone steroid[i]. In which case I am not aware of any reversing therapy, but would have sought a neurologist's advice and/or encouraged [Dr C] to do so.

v. A direct approach to the patient under the circumstances would not have been appropriate — even though she did not make any uncomplimentary mention about

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him or his manner at the consultation. She only fed back that she has had a severe undesired outcome.

vi. In my opinion he should have been in touch with [Dr C] to ensure appropriate alternative assessment or care — possibly through an alternative same-type specialist or by such as a neurologist in view of the actual adverse outcome symptoms described.

vii. I my opinion failing to do this was a **[MILD]** breach of the expected standard of care, on account of it being mitigated by [Mrs A] indicating she was already in another doctor's care for same, and there being no *essential* treatment she was missing out on.

viii. He could have lessened her antipathy to him by acknowledging her unexpected distress and expressed to her his regret that this had happened, without taking on self-blame, as some undesired outcomes do happen even from excellent practitioners.

b. If [Dr B] had not received [Mrs A's] email, what would I expect him to have done after she failed to attend her scheduled f/up appointment on 15 May 2012?

i. You pose a difficult question with this. Failure to keep appointments is relatively common in chronic pain management practice. Mostly it is not related to dissatisfaction with a consultation per se, but not liking the messages is a common reason for non return.

ii. I consider that if no adverse outcome had been communicated (either by [Mrs A], or the GP referrer) then there was unlikely to be a significant risk to the patient from not attending.

iii. Therefore the most he could have been expected to do would be send another appointment and leave it for the patient to decide whether to attend or not.

iv. In my opinion this is **NOT** a concerning breach of the standard of care.

I hope these responses assist you to take this matter to a conclusion. I am happy for you to contact me if you need anything in this report clarifying.

Signed:

David Jones FANZCA FFPMANZCA 29 May 2013"

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[i] See: Russegger L, Schröder U, Langmayr JJ, Twerdy K. Intrathecal administration of triamcinolone after discectomy. Wien Klin Wochenschr. 1997 Oct 31;109(20):808-11, who report '(13%) postpunctional signs ... from slight to severe headache with nausea and vomiting...'

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