Anaesthetist, Dr B

A Private Hospital

A Report by the

Health and Disability Commissioner

(Case 07HDC08687)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer/complainant
Dr B	Provider/anaesthetist
Dr C	Surgeon
Ms D	Registered nurse
Ms E	Registered nurse
Dr F	Dermatologist
A private hospital	Provider

Complaint

On 21 May 2007, the Commissioner received a complaint from Ms A about the services provided to her by Dr B and a private hospital (the Hospital). The following issues were identified for investigation:

- *The appropriateness of the care provided to Ms A by Dr B between 16 October 2006 and 19 October 2006.*
- *The appropriateness of the care provided to Ms A by the Hospital between 16 October 2006 and 21 October 2006.*

An investigation was commenced on 16 August 2007.

Information reviewed

Information was obtained from:

- Ms A
- Dr B
- Chief Executive Officer, the Hospital
- Registered Nurse Ms E
- Registered Nurse Ms D

Independent expert advice was obtained from anaesthetist Dr Joe Sherriff.

Information gathered during investigation

Overview
On 16 October 2006, Ms A, aged 42, underwent a vaginal hysterectomy and laparoscopic colposuspension[1] procedure. The procedure was carried out by general surgeon Dr C at the Hospital. Dr B was the anaesthetist.

Ms A was in significant pain after the operation and Dr B inserted a caudal block.[2] Ms A says that she was not told about the proposed use of a caudal block. She would never have consented to the procedure, as the area where Dr B injected the needle was affected by psoriasis.[3] She understood that Dr B was going to insert an epidural.[4]

The area around the injection site later developed into a blister and became ulcerated. Ms A also complained that nursing staff should have taken steps to prevent the area from becoming ulcerated.

Information gathered

Preoperative assessment/consultation
Prior to her surgery, Ms A completed an anaesthesia assessment form. She listed her previous surgery — the insertion of a Mirena[5] in August 2006, a Caesarean section in June 1994, and a tonsillectomy in 1999. She also recorded that she suffered from psoriasis.

On 16 October 2006, at approximately 1.45pm, Ms A arrived at the Hospital for her surgery. As part of the preoperative preparation, it was intended that Ms A would have an enema to ensure her bowels were empty prior to surgery. However, Ms A declined this because she had psoriasis in this area, explaining that it was sore and prone to infection. This is not documented in the clinical records; however, it is documented under "skin condition" on the nursing assessment record that Ms A had "psoriasis — patchy".

Immediately prior to surgery, Ms A was seen by Dr B for a pre-anaesthetic consultation. Before meeting Ms A, Dr B reviewed the nursing assessment record and anaesthetic questionnaire. The nursing assessment form noted that Ms A had concerns about her postoperative pain management. During the consultation, Ms A specifically asked about postoperative pain relief, advising that she had previously had a tonsillectomy following which the postoperative pain relief had been inadequate.

---

[1] An operation to treat incontinence of the bladder.
[2] A type of regional anaesthesia which is injected into the spinal cord at the level between the sacrum and coccyx and produces a regional sensation block of the lumbar and sacral nerve roots.
[3] A skin condition characterised by red scaly patches.
[4] Another form of regional anaesthesia which is generally inserted at the level of the lumbar vertebrae.
[5] A form of contraception.

Dr B explained that, given Ms A's concern, he described to her the pain relief that he routinely used, and gave specific details about his postoperative pain management. This included the preoperative use of oral paracetamol and Celebrex (a non-steroidal anti-inflammatory drug); intravenous (IV) Clonidine (enhances local anaesthetics and analgesics) during the operation; and regular oral pain relief and IV pethidine (an opioid drug) postoperatively. Dr B stated that he also assured himself that Dr C would be using long-acting local anaesthetic during the operation. The anaesthetic consent form records that Ms A's concerns about her postoperative pain relief had been discussed. Dr B stated:

> "I gave details of postoperative pain management to [Ms A], especially because that was worrying her most. … I did not 'guarantee' that my methods of anaesthesia would be 100% effective. However I did have reason to be confident that my chosen regime of anaesthesia, in combination with pain relief used intra-operatively by the surgeon [Dr C] would be successful, because of our extensive experience and the lack of complications in the past."

Dr B considered that Ms A was provided with sufficient information preoperatively. He saw limited value in informing patients of the back-up options for postoperative pain relief at the time of the preoperative assessment, one hour before surgery, when they are also being prepared by nurses and the surgeon. Furthermore, Dr B explained that the information he provides preoperatively depends on a number of factors, including the type of procedure, existing co-morbidities, as well as previous anaesthetic experience.

In contrast, Ms A felt that Dr B was dismissive of her concerns, taking no time to discuss what would happen should the pain relief be ineffective. Ms A advised that Dr B just patted her hand and told her not to worry.

Surgery — 16 October 2006

Ms A was taken into surgery at approximately 3pm. Surgeon Dr C undertook a vaginal hysterectomy and a laparoscospic colposuspension procedure. The surgery was uneventful and completed shortly after 5pm. Ms A was transferred to the recovery room at 5.12pm.

Postoperative care

Ms A was in pain when she regained consciousness at approximately 5.15pm. Dr B was called and reviewed Ms A at approximately 5.30pm. He noted that Ms A was complaining of pain when roused, but was also able to fall asleep again. Dr B felt that Ms A was still too drowsy for him to assess her pain properly. He decided to continue with IV pethidine until she was less drowsy, as this would enable a better assessment of her pain. Accordingly, 20mg of pethidine was administered at 5.21pm, 5.26pm, 5.34pm, 5.40pm and 5.45pm.

Shortly after 6pm, registered nurse Ms D went to the recovery room to collect Ms A. Ms D noted Dr B's advice to continue with pethidine and decided to transfer Ms A to the ward. She was transferred at 6.15pm.

Following her transfer to the ward, Ms A's pain continued. Ms D stated:

> "[Ms A] [k]ept asking why she was left in pain when it had been promised that she would not be sore. I explained I would do my best to help and tried to make her position more comfortable."

Ms A was given a further three 20mg doses of IV pethidine at 6.22pm, 6.25pm and 6.28pm. However, she continued to complain of pain around the drain site in her left lower abdominal area. Ms D also noted that Ms A's respiratory rate was raised, indicating she was in some distress. Ms D decided to contact Dr B.

After he had been informed of Ms A's continuing pain, Dr B advised that he would insert a caudal block. Ms D informed Ms A of Dr B's plan, explained how the caudal block would be inserted, and what effect this would have. Ms D recalls that Ms A expressed some concern about the plan. Ms A has no recollection of this. Ms A recalls that she said this would need to be discussed with Dr B when he arrived. Ms D offered further pethidine which Ms A declined as she wanted to have a clear head when Dr B arrived.

Caudal block

Dr B arrived on the ward at approximately 7pm. Following his assessment, Dr B confirmed that a caudal block was appropriate. In making his decision, Dr B considered a number of factors, including the location of Ms A's pain and her response to the pain relief already administered. Dr B explained:

> "… [Ms A] had received an oral analgesic and [a] reasonably large dose of narcotic in a fairly short period of time, local anaesthetic had been infiltrated intra-operatively, and the preemptive use of an effectiveness enhancer (clonidine). These had not reduced her significant postoperative pain. I considered that more of the same medications were not promising/ likely to improve the situation."

Dr B also considered the availability and skills of the nursing staff, the technical difficulties such as difficulty in positioning and locating the correct landmarks, and the potential for infection.

Dr B did not believe there was any risk of infection. He advised that, prior to inserting the needle, he used an alcohol swab to sterilise a small area around where the needle was going to be inserted. In addition, Dr C had already swabbed a larger area prior to surgery. Antibiotics had also been administered at the beginning of the operation. Had the area been infected, Dr B would have deferred the procedure. He was therefore confident that the area was not infected.

Taking into account all of these factors, Dr B felt that the indications for the caudal block outweighed the contraindications, and concluded that it was the best option for controlling Ms A's pain.

It is a requirement under the Hospital *Bylaws for Attending Medical and Dental Practitioners* that the attending practitioner, in this case Dr B, provide adequate information to the patient and obtain consent for the procedure. This duty may not be delegated.

According to Dr B, before proceeding he gave Ms A a description of the procedure and his reasons why he felt it was the best option. He was aware that Ms A was concerned about having an injection in an area affected by psoriasis and that she had earlier declined an enema for this reason. However, it was Dr B's belief that, following his discussion of the procedure, Ms A understood the situation and consented to the procedure. Dr B stated:

> "I believe that … [Ms A] was informed as to what the procedure entailed and the reasons for it being offered to her as the most effective and speedy option in the circumstances. That [Ms A] co-operated as observed by me and noted by the nurse indicated to me her acceptance of it."

No one else was present during the discussion and there is no record of the information given to Ms A, or of her consent. Dr B acknowledged the lack of documentation. He stated: "With hindsight, given her initial concerns I should have recorded something of the consent, and information given." Dr B also stated:

> "With the benefit of hindsight it is easy to say that more should have been said to [Ms A] regarding postoperative pain relief. Seeing patients well ahead of operation is ideal but happens only unusually due to the availability of beds, economic considerations and personal convenience of people involved (both patient and doctors). Retention of information given so close to the operation is frequently recognized to be unsatisfactory."

Ms A does not recall the consultation with Dr B. She understood from the information given by Dr B that he would be inserting an epidural, which she had experienced during childbirth.

It was not until Dr B swabbed the area that Ms A realised where the block was to be inserted. At this point Ms A insisted that she did not want to proceed. Ms A stated:

> "The swab hurt a great deal as my skin there is very weak and sensitive and I verbally protested as loud as I could. I also tried to wiggle my body to stop them doing what they were about to do."

Ms A felt that her concerns were ignored. When she tried to physically resist she was "manhandled" by the two nurses and told to keep still. Ms A recalls:

> "I did in the end keep still as I could see that they meant to give me this procedure even though I did not want it and I was worried about moving as the needle went into my spine. However the act of keeping still was by no way consent on my part."

In contrast, Dr B advised that no restraint was used. He explained that one of the nurses, Ms D, assisted Ms A to stay in the correct position (lying on her left side, with her knees pulled up), which is standard practice for this type of procedure. Ms D stated:

> "When [Dr B] was ready, I explained that we needed to roll [Ms A] on to her side, which was very uncomfortable for her. I told her to put her arm around my waist when she was on her side and said that I would hold her legs behind her knees and around her shoulders to support her so she would not move while [Dr B] did the procedure … She did this and appeared to understand the reasons behind it."

Ms D advised that because Ms A had psoriasis over her back, as far as her gluteal crack, it was very painful when Dr B swabbed the area with alcohol.

Registered nurse Ms E does not recall Ms A resisting during the procedure. Ms E stated:

> "From what I remember, [Ms A] was not yelling out during the procedure due to her psoriasis. At the time she was more focused on getting her pain level low rather than worry about her sore bottom."

Ms A stated:

> "Why did the nurses who saw me have an injection into a very red and sore patch of psoriasis not tell the next nurses so they could make sure I was moved and the injection [site] was checked?"

Dr B explained that after Ms A had been placed in an appropriate position he swabbed the area with an alcohol swab. He knew this was very painful for Ms A, but she was still co-operative. Dr B then proceeded to insert the needle.

The insertion of the caudal block was not documented fully by Dr B or the nurses. The clinical records state:

> "Pain in [left] lower quadrant. Not controlled by 160mg pethidine since getting to [recovery room] at 1715 [hours]. [Therefore] caudal …"

Dr B requested that Ms A remain on her side for half an hour following the insertion of the block. Half an hour later Ms A's pain had improved significantly and Ms D and Ms E were able to give Ms A a wash. They took particular care around her lower back and gluteal area. Ms D noted the severity of Ms A's psoriasis and offered to apply

some of Ms A's psoriasis cream to the affected area. Ms A declined. Ms A then requested that she be helped onto her back.

Dr B stayed on the ward until he was satisfied that the block had taken effect. At 7.30pm he also wrote a prescription for patient-controlled analgesia (PCA) of 10mg doses of pethidine, limited to 150mg in each four-hour period. Dr B believed that the nursing staff would contact him if they had any concerns.

At approximately 8.30pm the PCA was set up according to Dr B's prescription. Ms A was encouraged to use this when she experienced any pain. Ms D offered to assist Ms A onto her side, but this was declined.

Ms A commented that while staff may have advised her to change position, no reason for this was given. She stated:

> "I had no idea that a pressure area sore was building up underneath me. The nurses had all the knowledge. They knew that I had received an injection into an area where the skin was already poor. They knew that pressure sores come from being in one position for too long. They should have been coming to me every couple of hours, awake or asleep and making sure that I moved around."

According to the Hospital, prior to surgery it is standard procedure for nursing staff to carry out a full assessment, including noting any observations of the skin integrity and pressure area care. Patients are told to change their position regularly. However, there is no formal protocol for pressure area management for the type of gynaecological surgery Ms A underwent, as such patients are mobilising on the second postoperative day, and are not at risk of developing pressure sores.

17 October 2006
The following day Ms A's catheter and drain were removed and her PCA was discontinued. The clinical records document that Ms A was "mobilising well around ward" and was "comfortable".

In contrast, Ms A recalls remaining in bed for most of the day. She does not recall any nursing or medical staff checking the injection site.

18 October 2006
Ms A advised that when she got up to go to the toilet at approximately 2am she noticed blood on her underwear. When she looked in a mirror she noticed a small circle just above her gluteal crack which looked black and was oozing. When she raised her concern with the night nurse, Ms A said that the nurse didn't know what to do about it.

The clinical records documented by the night nurse state that Ms A complained of an abrasion between her buttocks. The plan was to notify the day shift nurses and to arrange for a doctor to review Ms A.

The following morning, it was noted that the skin had broken down around the caudal block insertion site. Zinc and castor oil were applied to the affected area. Dr C was later contacted and visited Ms A that evening. Ms A recalls discussing with Dr C the best way to manage the area. It was agreed that he would contact her dermatologist, Dr F, which he subsequently did. Dr C documented:

> "Intergluteal fold area of blackened skin approx. 2cm total — quite mobile. No true necrosis of [subcutaneous] tissue. First impression — psoriasis/fasciitis. Telephoned [Dr F]/cell messages only/ nil else at present."

19 October 2006
On 19 October 2006, dermatologist Dr F contacted Ms A directly. Dr F recalls Ms A describing what he understood to be a blood blister which initially started to bleed and then turned white. Dr F contacted Dr C to advise him of the advice he had given Ms A and faxed through a prescription for Bactroban, an antibiotic cream.

Ms A continued to manage her psoriasis and the affected area herself, applying the antibiotic cream. The wound was noted to be dry.

Ms A made it very clear to hospital staff that she was unhappy with the care she had received and that she blamed both the hospital and Dr B for the ulcer that had developed. She had "lost all confidence in the hospital to care for me as a patient with psoriasis".

Dr B visited Ms A and went over what had happened on 16 October 2006 to ensure that she understood his actions. He thought she did.

Ms A recalls that she had no warning of Dr B's visit. She stated:

> "He brought a nurse with him who stood behind him while he spoke to me. I wasn't even dressed properly, just in a nightgown. If I had been told he was coming then I would have had a family member there to support me."

Ms A found this was very intimidating. She believes that as soon as she had made it clear to hospital staff that she was unhappy with the care she had received, she should have been offered the support of an advocate. Instead, she felt that the hospital was trying to convince her that it was not their fault.

20–21 October 2006
The records document that Ms A continued to progress well over the next few days. She was discharged on 21 October 2006. Her wound was noted to be healing well.

Ongoing care
Ms A's sister is a nurse. Following Ms A's discharge from hospital, her sister looked at the wound. She thought it looked like an ulcer and recommended that she consult dermatologist Dr F.

Ms A made an appointment to see Dr F immediately, and he saw her on 25 October 2006. He noted an ulcerated area centrally between her buttocks. Dr F recommended that she continue to apply Bactroban. He also advised her to use an antiseptic in her bath water and apply Paranet (non-adhesive) dressings.

The ulcer was in an area that made it very difficult to treat, so Ms A contacted her general practitioner and requested a district nurse referral. This was completed by the practice nurse and faxed through to the community health service on 26 October 2006.

Ms A was first seen by a district nurse on 27 October 2006. The clinical records show that Ms A had been experiencing significant pain from the ulcer. The area was documented to be the size of an old 20 cent coin. It was also documented that it appeared to be superficial but with 100% slough. The ulcer was dressed with Bactroban and gauze.

Ms A continued to be seen regularly[6] by the district nurses for dressing changes and monitoring of the ulcer. The ulcer was documented to be healing well and Ms A was discharged from district nursing on 29 November 2006.

Independent advice to Commissioner

Expert advice was obtained from anaesthetist Dr Joe Sherriff. Dr B commented on Dr Sherriff's initial advice. Dr Sherriff then provided further advice. All this material is attached as Appendix A.

Response to provisional opinion

Dr B

In response to the provisional opinion, Dr B (who has now retired, for personal reasons unrelated to this case) stated that he considers some of Dr Sherriff's criticisms unreasonable, and disagrees with some of my findings.

In relation to whether an adequate back-up plan was in place preoperatively, particularly taking into account Ms A's concerns, Dr B reiterated that her concerns were taken into account. Dr B advised that, in light of her concerns, he took steps to reassure her, discussing in detail the pain management plan he was going to use. It was his understanding that she was happy with his explanation.

[6] Ms A was seen on 28 and 30 October and 1, 4, 6, 9, 13, 17, 22 and 29 November.

In relation to Dr Sherriff's criticism that he failed to administer a long-acting analgesic during the operation, Dr B advised that analgesia and method of administration is a matter of personal choice. If there were one "foolproof" method everyone would use it. Dr B explained that what is important is close monitoring and the facility for "swift effective response". He believes his management of Ms A was appropriate.

Dr B stated that he did consider the risk of infection. He is confident that the area around where the caudal block was inserted was not infected, nor was Ms A in an environment in which she was susceptible to infection.

In conclusion, Dr B reiterated that he was acting in Ms A's best interests in deciding to insert the caudal block. He stated:

> "I was doing my best for [Ms A] at all times. As soon as the cause of pain was identified I acted to relieve her pain in the best way I could under very difficult conditions and succeeded in doing so."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are 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.

RIGHT 6
Right to be Fully Informed

(2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

(1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

Other relevant standards

- Australian and New Zealand College of Anaesthetists (ANZCA) *Guidelines on consent for anaesthesia or sedation* (2005)
- ANZCA *The Anesthesia Record, recommendations on the recording of an episode of anaesthesia care* (2006)
- ANZCA *Guidelines for the management of major regional analgesia* (2003)
- ANZCA *Recommendations on the pre-anaesthesia consultation* (2003)
- The Hospital *By-laws for attending medical and dental practitioners* (2004)

  "Part 2 Policy and Procedures

  …

  8.3 Consent:

  It is the duty of the Attending Practitioners to ensure that all patients that have been admitted under their care for treatment and/or operative procedures receive a full explanation of the nature of the procedures so that the patient may understand the nature and consequences of what is proposed and may give his/her informed consent. This duty may not be delegated."

Opinion: Breach — Dr B

Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) Ms A had the right to services provided with reasonable care and skill.

Under Right 6(2) of the Code, Dr B had a duty to provide sufficient information to allow Ms A to make an informed choice about the provision of services. Dr B also had an obligation to ensure that Ms A gave informed consent before he inserted the caudal block (Right 7(1) of the Code). This was also a requirement under the Australian and New Zealand College of Anaesthetists (ANZCA) guidelines and the Hospital by-laws, which clearly indicate that this is the doctor's responsibility and may not be delegated.

Preoperative consultation
On 16 October 2006, Ms A was admitted to the Hospital for an elective vaginal hysterectomy and laparoscopic colposuspension. Prior to being taken into surgery Ms A was seen by Dr B for a preoperative anaesthetic consultation. This was the first time she had met Dr B.

After a previous bad experience, Ms A was concerned about her postoperative pain management and she raised this directly with Dr B during this consultation. Dr B has confirmed that he was aware of Ms A's concern about postoperative pain and said he gave her an explanation of his usual regime. He reassured her that he had never had any problems using this method in the past. Dr B believes there is limited value in providing a patient with information about back-up plans for analgesia one hour before surgery. This is particularly so when other factors such as the type of procedure being performed are taken into account. Dr B considered that he provided Ms A with adequate information.

I accept that careful consideration must be given to the amount of information given to a patient in this preoperative period. However, the circumstances of the individual patient must be taken into account. Ms A was clearly very concerned about her postoperative pain management. In my view, Dr B should have discussed alternative options with her at this time. This would have given Ms A the reassurance she sought. My expert advisor, Dr Sherriff, commented that it was "distinctly foolhardy" for Dr B to reassure Ms A without any consideration or discussion of a back-up plan.

Choice of anaesthetic

Dr B advised that the pain relief methods he normally uses include administering Panadol and a longer acting anti-inflammatory such as Celebrex preoperatively. He administers Clonidine during the operation, which enhances the effects of local anaesthetic and analgesic agents. Postoperatively, pethidine is given intravenously as required, together with regular oral pain relief. Dr B stated that he has never experienced any problems with this method in the past. In addition, local anaesthetic is administered to the incision area by the surgeon during the operation. Dr B has worked with Dr C for 30 years and has found that the way he performs surgery results in the patient experiencing less pain postoperatively.

While Dr Sherriff accepts that Dr B may not have had any problems with this regime in the past, in his view Dr B should have administered a long-acting anaesthetic such as pethidine or morphine during the operation. Dr Sherriff views Dr B's failure to do so as a minor departure from standards.

Caudal block

Postoperatively Ms A experienced a significant amount of pain that did not respond to the prescribed medications. Dr B was subsequently contacted and told the nurse that he intended to insert a caudal block.

When Dr B returned to the ward he reviewed Ms A and confirmed his decision to insert a caudal block. He said that he then discussed this plan with Ms A, providing a description of the procedure and the reasons why he felt this was the best option for controlling her pain. While he was aware that Ms A had psoriasis and was concerned about a needle being inserted in this area, he felt that following his discussion Ms A understood his reasoning and consented to the procedure.

In contrast, Ms A does not recall any explanation of the procedure, although this may be because of the sedative medication she had received. Her recollection is that she thought that Dr B was inserting an epidural in her lumbar spine area which was not affected by psoriasis. It was not until Dr B swabbed the area that Ms A realised where he planned to insert the needle. Ms A recalls that at this point she made it very clear she did not want the procedure. However, neither Dr B nor the nurses recall Ms A resisting or expressing any concern about the procedure and there is no record of this in the clinical records.

The ANZCA *Guidelines for the management of major regional analgesia* state: "Informed consent must be obtained from the patient prior to the institution of any regional analgesia and prior to sedation."

Dr B advised that while he is aware of the College guidelines, it is a matter of clinical judgement whether the patient is competent to understand information provided and consent to a procedure. In this case, Dr B believed that Ms A understood and consented to the procedure. He also considered that, in the circumstances, a caudal block was the only option available to him.

I am unable to determine exactly what discussion occurred between Dr B and Ms A prior to Dr B inserting the caudal block. In any event, it is doubtful whether Ms A was in a fit state to make a decision. The ANZCA *Guidelines on consent for anaesthesia or sedation* state that consent may only be given by a person capable to do so. Clause 1.2.1 states:

> "1.2.1 All persons are presumed to be competent to give consent, unless there are reasonable grounds for believing otherwise. A judgement that the patient is incapable of giving consent must be supported by appropriate evidence, such as … presence of sedative medication."

Ms A awoke from a general anaesthetic approximately two hours prior to Dr B discussing the caudal block with her. She has no recollection of any discussion about the procedure with the nurse or Dr B. The obvious inference is that Ms A was still recovering from the residual effects of the general anaesthetic and was not in a fit state to make a decision.

I note Dr Sherriff's advice that "if there is any doubt about the ability of the patient to give consent, it would be wise to avoid any procedure which is not routine, mainstream practice". I also note Dr Sherriff's comment that there were several alternatives to a caudal block which were not considered.

Dr B explained that the decision to insert a caudal block involves consideration of a number of factors including the patient, the situation, and the ease and practicality of insertion. Given Ms A's previous response to systemic analgesic, he considered that administering more of this type of analgesia was unlikely to improve her pain. Taking into account the location and severity of Ms A's pain, the time of night and the limited

availability of experienced nursing staff, and the severity of Ms A's pain, Dr B decided the best option was to insert a caudal block. This is a commonly used technique and in his view the "indications for the caudal block were stronger than [the] contra-indications".

Dr B did not consider that Ms A was at risk of infection. He had swabbed the area with an alcohol swab around where the needle was to be inserted, and a wider area had already been swabbed by Dr C prior to surgery. If the area had been harbouring infection surgery would have been postponed. Furthermore, Ms A had already received antibiotic medications.

However, Dr Sherriff advised that caudal anaesthesia involves the insertion of a needle into the epidural space between the sacrum and coccyx and consequently there is a high risk of introducing infection into the epidural space. Dr Sherriff considers a potentially infected skin condition such as psoriasis at the site of injection is a strong contraindication. The ANZCA *Guidelines for the management of major regional analgesia* state that the general ward is not an appropriate environment in which to insert any type of regional anaesthesia, including a caudal block.

Conclusion

Ms A had the right to adequate information about the risks and benefits of inserting a caudal block, including strategies for managing any side effects, and information about other safe alternatives. She would then have been able to give informed consent for the procedure. Ms A also had to be competent to make this decision. This is a requirement under the Code and the ANZCA guidelines.

It is clear that Dr B was in a very difficult situation. I accept that he may well have explained the caudal block procedure to Ms A and believed that she gave her consent. However, there is no documentation to support his claim that he did so. In any event, Ms A was in no state to give her consent. Dr B should have been aware of her individual circumstances. He should have anticipated the need, prior to surgery, to provide more information to address her concerns about postoperative pain.

Overall, I consider that Dr B failed to provide the information Ms A needed and did not obtain her consent to the caudal block. Accordingly, Dr B breached Right 6(2) and 7(1) of the Code.

I accept that clinical practice varies dependent on a number of factors such as personal preference and experience. Dr B clearly has a considerable amount of experience and has worked with Dr C for many years. I acknowledge that he has never experienced any problems in the past. However, I accept Dr Sherriff's advice that Dr B did not administer adequate pain relief to Ms A intra-operatively.

I also consider that it was unwise for Dr B to administer the caudal block on the ward given the risk of infection, particularly taking into account Ms A's known psoriasis. I acknowledge that Dr B may have considered the risk of infection prior to inserting the

caudal block. I also accept that the ulcer that subsequently developed may not have been caused by the caudal block insertion. That does not alter the fact that Dr B failed to minimise the risk of infection. In summary, I conclude that Dr B breached Right 4(1) of the Code by failing to provide Ms A with appropriate intra-operative pain relief and to minimise the risk of infection.

The Hospital — No further action

During the nursing assessment prior to surgery, Ms A informed nursing staff about her concerns about postoperative pain. She advised that she had psoriasis over her lower back and gluteal area, and chose not to have an enema as part of the standard preparations because of her concern about aggravating the area. This information was recorded on the preoperative nursing assessment form.

Caudal block
When Ms A suffered severe pain postoperatively, registered nurse Ms D contacted Dr B, requesting that he come in and review Ms A. Dr B agreed to come in, advising that he planned to insert a caudal block. Ms D advised that she briefly discussed the proposed procedure with Ms A, although Ms A does not recall this discussion.

After his arrival on the ward Dr B discussed the procedure with Ms A. No one else was present during this discussion. Registered nurses Ms D and Ms E then assisted Dr B to insert the caudal block. As noted above, Ms A had not consented to the block and recalls resisting its insertion. The nurses recall Ms A experiencing some pain when the area was swabbed, but do not recall Ms A resisting or expressing any concern during the procedure.

It was Dr B's responsibility to obtain informed consent for the procedure. I accept that the nurses made an assumption that Dr B had already obtained consent for the procedure in accordance with standard procedures.

Postoperative care
Following the insertion of the caudal block, Ms D and Ms E cared for Ms A. Ms D recalls that she noted the severity of Ms A's psoriasis while washing her and offered to apply Ms A's psoriasis cream to the affected areas, but Ms A declined this. Ms A was then assisted onto her back and chose to remain in this position for the rest of the night. Ms D offered to assist Ms A to turn onto her side on a number of occasions, but Ms A declined this.

The clinical records note that the following day Ms A was mobilising on the ward. On 18 October 2006, two days after the surgery, Ms A noted a patch of skin in her gluteal area that had broken down, and notified nursing staff. The clinical records document Ms A's concern and the plan for the morning shift nurses to arrange for a medical

review. Dr C was subsequently notified. He contacted Ms A's dermatologist, Dr F, for advice. Dr F gave Ms A advice about how to manage the affected area.

While Ms A accepts that nursing staff may have suggested that she move off her back, she said that no one ever told her why. She stated:

> "I had no idea that a pressure area sore was building up underneath me. The nurses had all the knowledge. They knew that I had received an injection into an area where the skin was already poor. They knew that pressure sores come from being in one position for too long. They should have been coming to me every couple of hours, awake or asleep and making sure that I moved around."

Ms A also stated that she had "lost confidence in the hospital to care for me as a patient with psoriasis".

The Hospital has advised that there is no formal protocol for pressure area management for the type of gynaecological surgery Ms A underwent because such patients are mobilising on the second postoperative day. They are therefore not considered to be at risk of developing pressure sores. However, it would have been good practice for the nurses to ensure that Ms A understood why she needed to turn regularly while she was in bed. I accept that nursing staff acted appropriately in notifying Dr C once they were aware of the area of skin breakdown.

Conclusion
In the circumstances, I do not consider the care provided by the Hospital warrants a finding that the Code was breached. However, I recommend that hospital management remind staff of the importance of clear communication with patients, in light of this report.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.
- A copy of this report, with details identifying the parties removed (except the name of Dr B), will be sent to the Australian and New Zealand College of Anaesthetists and the New Zealand Society of Anaesthetists.
- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A

Report by Dr Joe Sherriff to the Health and Disability Commissioner regarding complaint 07/08687 by [Ms A]

I have been asked to provide an opinion to the Commissioner on case number 07/08687 regarding a complaint by [Ms A]. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I graduated MB ChB at Manchester University in 1975. After 2 years of junior hospital posts and General Practice, I then trained as a Specialist Anaesthetist. Most of the training was in Dundee, Scotland and in Dunedin. I obtained the Fellowship of the Faculty of Anaesthetists of the Royal College of Surgeons in 1979 and the Certificate of Higher Specialist Training in 1982.

Since then I have worked as a specialist anaesthetist in Barrow-in-Furness, England and Invercargill, New Zealand. I was elected to the Fellowship of the Australian and New Zealand College of Anaesthetists in 2003.

I was Director of Anaesthesia for 4 years of my UK post and 6 years of my time in Invercargill. Currently I am the College of Anaesthetists Supervisor of Training of our registrars. I have run our departmental Audit and Quality Assurance Program for the last 13 years. I work both in Southland Hospital, employed by Southland District Health Board, and at Southern Cross Hospital, Invercargill in Private Practice. For most of my 26 years as a specialist I have anaesthetised for gynaecological surgery on a regular basis. I have a very extensive experience of spinal, epidural and caudal anaesthesia.

The Commissioner has asked me to provide independent expert advice about whether [Ms A] was provided with the appropriate standard of anaesthetic care.

I do not know, nor have I met either [Ms A] or [Dr B]. I have not visited [the Hospital] and know none of the staff there.

The Commissioner informed me that [Ms A] was admitted to [the Hospital] for vaginal hysterectomy and laparoscopic colposuspension, which were performed on 16th October 2006. Following surgery, [Ms A] required analgesia, and the Anaesthetist [Dr B] inserted a caudal block as other analgesia had proved ineffective. [Ms A] complained that the caudal block was performed against her wishes, which [Dr B] disputes, and that a caudal block was not discussed preoperatively, which [Dr B] agrees with.

[At this point Dr Sherriff refers to the information provided to him by this Office. This information has been omitted for the sake of brevity.]

…

Account of the events as obtained from the documents provided
[Ms A] was admitted to [the Hospital] at 13.45 on October 16th 2006. Prior to being taken to the operating theatre at 15.00, she was seen by [Dr B] for a preoperative anaesthetic consultation. He reviewed the Anaesthesia Assessment – Patient Questionnaire and the admission nurse's notes.

He noted that she was taking Spironolactone (a potassium sparing diuretic), that she had psoriasis on her back and perineum, and was allergic to tetracycline.

Both he and [Ms A] signed an anaesthetic consent form, on which [Dr B] noted that they had discussed General Health, medications, allergies, dentition, and previous general anaesthetics. He also noted that [Ms A's] only concern was postoperative pain control and that this was explained.

[Ms A] recalls that this explanation consisted of informing her that he would use Pethidine and that he made sure all his patients were free of pain following surgery. She implies that there was no discussion of regional anaesthetic techniques or strategies for coping with pain should Pethidine prove to be inadequate.

He prescribed Celecoxhib, an anti-inflammatory analgesic and Paracetamol which were given preoperatively.

[Ms A] entered the operating theatre at 15.00 and [Dr B] inserted a small cannula in a vein in her right forearm. Anaesthesia was induced with Midazolam 2.5mg, Vecuronium 4mg, Alfentanil 0.5mg and her ventilation maintained through an endotracheal tube. Anaesthesia was maintained with Desflurane. Dexamethasone, Ondansetron and Clonidine were given intra-operatively. A further illegible drug that I presume was the antibiotic Ceftriaxone, was given. Dexamethasone is an anti-inflammatory steroid commonly given intra operatively to reduce postoperative nausea and vomiting. Ondansetron is an anti-emetic and Clonidine is an alpha adrenergic agonist which though neither a sedative nor an analgesic, supplements other drugs that have those actions.

Other than Bupivacaine, a local anaesthetic which would have been given by the surgeon it appears that no long acting analgesic was given intra-operatively.

[Ms A] was transferred to the recovery room at 17.12 and recovered consciousness almost immediately. Despite initially being sleepy she was noted to be very sore every time she woke and was given Pethidine 100mg over the next 30 minutes. The recovery nurse notes that she asked [Dr B] about alternative analgesia but he asked to continue with Pethidine. She was also given Paracetamol 1gm, orally.

At 18.15 she returned to the ward. She was clearly in a lot of pain, complaining that she had been told she would be pain free, and was noted as having a pain score of 8/10. She was given a further 60mg of Pethidine with little effect. The nurse noted that

the pain appeared to be localized around the drain side in the left lower quadrant of her abdomen.

[Dr B] was called at 18.30 and the nursing notes quote him as saying he was surprised that she was so sore and that he would come in and put a caudal block in place.

He arrived and made a note that he administered a caudal block at 19.15 with Marcain (the trade name for Bupivacaine) 0.5% 20ml with adrenalin. There is no record of information given to [Ms A] or of her consent. There is also no record of her position, any aseptic precautions, the technique or the equipment used.

The contemporaneous nursing notes make no mention of any of the above. In addition there is no indication of whether any restraint of [Ms A] was needed to allow [Dr B] to perform the caudal.

The retrospective reports by [Ms A], [Dr B] and the ['Feedback Report – Nursing Staff'] have considerable differences regarding the insertion of the caudal.

The nurse states that while they were waiting for [Dr B] to arrive she explained how the caudal block would be done and how it would work and recalls that [Ms A] was "not too keen". The nurse advised her to talk to [Dr B] when he arrived.

The nurse was not present when [Dr B] spoke to [Ms A]. She describes how she rolled [Ms A] onto her side and helped her to curl up so that [Dr B] could do the caudal. She implies that [Ms A] was reasonably cooperative.

She notes that the alcohol skin preparation was very painful for [Ms A].

[Ms A] account indicates that her first postoperative recollection was waking in the ward and being told that the nurses were fetching [Dr B]. The nurse noted that [Ms A] refused further Pethidine so that she would have a clear head to talk to him when he arrived.

She does not recall any consultation with [Dr B], but does recall being rolled onto her side and given the injection despite her insistence that she did not want it. The description by [Ms A] of the insertion of the caudal injection and her attempts to persuade [Dr B] not to do it are very graphic, both in her initial complaint and in subsequent correspondence. Even if her distress has been exaggerated, it is beyond belief[7] that anyone would consider that she had given her informed consent.

Within 30 minutes her pain had improved considerably and the nurses were able to give her a postoperative wash, recalling that they were particularly careful around her lower back, buttocks and gluteal crease.

[7] In a subsequent report Dr Sherriff changed this statement. Refer to page 31.

In the ensuing days there was clearly a breakdown of her skin around the site of the caudal injection. Her postoperative pain was managed with Pethidine patient controlled analgesia for around 24 hours then pethidine tablets and oral paracetamol.

It would appear that [Dr B] did not visit [Ms A] again until the 19th October, 3 days postoperatively. [Ms A] recalls this in considerable detail and is clearly not satisfied with [Dr B's] explanation.

I will now comment on the various aspects of [Dr B's] care of [Ms A].

Preoperative consultation
The adequacy of this consultation is judged by the Australian and New Zealand College of Anaesthetists (ANZCA) Policy document PS27 Recommendations on The Pre-Anaesthesia Consultation. This took place in the hospital shortly before the operation. Whilst a consultation by the anaesthetist prior to that time is the ideal it is often impossible to arrange. From the comments by [Dr B] and [Ms A] it would appear that most of the recommendations were met, with the exception of information given and consent obtained.

[Ms A] asked specifically about postoperative pain relief and in answer was given a description of [Dr B's] usual regime and a reassurance that it always worked. The combination of a non-steroidal anti-inflammatory (Celebrex), an alpha adrenergic agent, Clonidine, an opiate, Pethidine and infiltration of local anaesthetic by the surgeon, was a reasonable choice and clearly worked well in [Dr B's] hands in most cases. However, to be so reassuring to [Ms A] that it always worked, with no consideration of a "Plan B" was distinctly foolhardy. It is easy to appear to be patronising when one is trying to be reassuring but I am sure [Ms A] would have been better reassured if [Dr B] had discussed some of the alternatives.

In particular, the possibility of either an Epidural or Spinal anaesthetic should have been discussed. It is virtually impossible to do laparoscopic surgery under a regional block alone, because of diaphragmatic stimulation. A combination of regional and general anaesthesia however is very successful and greatly increases the chance of the patient waking pain free and remaining so in the postoperative period.

Consent
There are two separate issues of consent in this case, firstly consent for the anaesthetic for the operation and secondly consent for the postoperative caudal block. The requirements for consent for anaesthesia are detailed in The Australian and New Zealand College of Anaesthetists (ANZCA). Policy document PS26, Guidelines on Consent for Anaesthesia or Sedation. These specifically refer to the Code of Health and Disability Services Consumers' Rights.

Though the counsel of perfection, it is almost impossible and very unusual for every last detail of information given to the patient to be documented.

My major concerns here are:

1. The lack of any preoperative discussion of epidural or spinal anaesthesia.

2. The lack of any realistic strategy for managing postoperative pain should [Dr B's] usual regime not be effective.

Information concerning risk is probably best given by written information for the patient to read prior to the consultation. Then, specific concerns relevant to that patient, that operation and the proposed anaesthetic can be discussed. There is no indication as to whether [Ms A] received such information.

With the exceptions noted above, the consent process for the anaesthetic, whilst not meeting every last detail of the guidelines appears to have been broadly acceptable. It would have been similar to practice throughout New Zealand, in both public and private hospitals.

Further comments regarding consent for the caudal block will be made later.

The Anaesthetic
Celecoxhib, 200mg and Paracetamol 2gm were given orally 25minutes prior to induction. This is common practice.

Intravenous induction with midazolam 2.5mg and Alfentanil 0.5mg and no Propofol is a little unusual, but I presume that the depth of anaesthesia was rapidly deepened with Sevoflurane before the paralyzing drug, Vecuronium took effect. Anaesthesia was maintained with the volatile agent Desflurane. The airway was protected with an oral endotracheal tube. Ventilation was controlled.

Thus far this was an acceptable anaesthetic.

Towards the end of the procedure Clonidine 150mg was given intravenously. I find it astonishing that no long acting powerful analgesic, e.g. Morphine or Pethidine, was given during the operation. Despite the Celecoxhib and Paracetamol given as preoperative medication, I would have expected [Ms A] to wake in severe pain with the drugs that had been given.

This failure to administer adequate analgesia intra-operatively was in my view a major[8] departure from acceptable standards, particularly as [Ms A] had expressed her concerns about postoperative pain relief.

Anaesthetic record
The Standard for Anaesthetic Records is the Australian and New Zealand College of Anaesthetists policy document PS6 'The Anaesthetic Record'.

[8] In a subsequent report Dr Sherriff changed this statement. Refer to page 31.

[Dr B's] record is a little sketchy, but meets virtually all of the requirements, especially when the nursing documentation is taken into account. With the notes by [Dr B] and the record of the vital signs direct from the monitor, on separate pages, it is not easy to correlate the two.

I do not have any major criticism of the anaesthetic record.

Recovery room management

[Ms A] woke in severe pain. Within 10 minutes she had been given Pethidine 40mg intravenously and the nurses quite reasonably asked [Dr B] if there an alternative could be given. Quite reasonably he said to carry on with the Pethidine and a further 60mg were given over the next 15 minutes. At this stage [Ms A] was still in severe pain and an alternative such as Morphine, Fentanyl or Tramadol should have been tried. Though in theory, all opiates affect the same receptors and should thus be equally effective, one sometimes finds that a change can make a difference. The individual response of patients to opiates is extremely variable. [Ms A] was not at all sedated when she left the recovery room so could have safely been given further opiate medication to try to get her comfortable.

[Dr B] could have done more to control [Ms A's] pain before she left the recovery room.

[Ms A] returned to the ward at 18.15. Her nurse was aware of her pain and quite correctly gave her a further 60mg of Pethidine as prescribed. She noted that the pain seemed to be coming from the drain site and called [Dr B]. Her comment that he "advised that he would be coming in to do a caudal block", indicates that he had decided on this treatment prior to reassessing [Ms A].

Before embarking on a caudal block for which there were several contraindications (see below) the following options could have been considered:

1. A change of intravenous opiate as suggested above.

2. Inspection of the site of the pain with possible local anaesthetic injection at the drain site.

3. Request for the surgeon to review, in the light of persistent pain, despite generous analgesia.

4. Return to the theatre suite to insert a lumbar epidural.

Postoperative Caudal Analgesia

There are two considerations here, firstly [Ms A's] concern that it was done without her giving consent and secondly whether it should have been done at all. I will consider the second of these first.

A caudal anaesthetic requires a needle to be inserted into the epidural space between the sacrum and coccyx. It is thus a form of central neuroaxial blockade and should be managed to the same standards as other epidural blocks. These are detailed in the Australian and New Zealand College of Anaesthetists Policy document PS3. Guidelines for the Management of Major Regional Analgesia.

In the first place I am surprised that [Dr B] achieved successful analgesia with a caudal injection. It would have been technically difficult in an uncooperative adult weighing 92kg. The anaesthetic is injected around the sacral spinal nerves and would have to track up the epidural space to the lower thoracic nerves to provide analgesia to the lower abdomen. In my experience it is unusual for analgesia from a caudal injection of 20ml of local anaesthetic in an adult to give a block higher than the second lumbar spinal nerve. Had it done so one would have expected the Bupivacaine 0.5% with adrenalin to give a motor block to the lumbar spinal nerves resulting in Ms A being unable to move her legs. There is no record of this occurring and one wonders if the improvement in pain was coincidental.

The risk of introducing bacteria into the epidural space is just as high with the caudal as with the lumbar approach to the epidural space. An epidural abscess, which could result from this, is a life threatening condition. A potentially infected skin condition such as psoriasis at the site of injection is a strong contraindication.

The College guidelines give a number of Principles regarding the establishment of major regional analgesia. These all add up to the conclusion that the general ward is not a suitable place. In particular it would be impossible to achieve adequate standards of infection control.

Consent for the Caudal

The accounts of [Ms A], the ward nurses and [Dr B] differ considerably in their opinions as to whether consent was given. It is not my brief to judge whose recollection might be nearest to the truth.

By the College Guidelines, Major Regional Analgesia does require informed consent. It "must be obtained from the patient prior to the institution of any regional analgesia and prior to any sedation."

This was neither requested nor obtained at the pre-anaesthetic consultation. [Dr B] acknowledges that [Ms A] would not remember his explanation of the caudal block because of the sedative drugs she had received and her severe pain. Thus he should have realised at the time that she was in no state to give informed consent.

If one takes [Ms A's] highly credible account at face value she specifically refused to give her consent.

I therefore do not believe that [Dr B] obtained adequate consent for the caudal injection and should not have proceeded.

Postoperative management
It appears that [Dr B] left the hospital as soon as [Ms A] was comfortable on the evening of October 16th and did not see her again until October 19th. I find it surprising that he did not visit the following day and subsequent days, especially given the unusual nature and severity of [Ms A's] pain.

Pethidine is not the ideal drug for administration by a Patient Controlled Analgesia (PCA) machine as its metabolites can accumulate and give significant side effects. Morphine or Fentanyl is more suitable. Fortunately this was not a problem as the PCA was only required for 24 hours.

The skin around the caudal injection site broke down over the following few days. This could have happened anyway as a result of [Ms A] lying on her back during the operation and postoperatively. The caudal is likely to have contributed, either from the effect of the injection itself or from pressure on the surrounding skin whilst it was anaesthetised.

Summary
[Dr B] failed to provide adequate anaesthetic care to [Ms A] in the following areas:

- He failed to provide adequate information preoperatively with regard to the possibility of providing a regional block to supplement general anaesthesia.
- He also failed to adequately address her concerns about postoperative pain.
- A powerful long acting analgesic should have been administered during the operation.
- In the Recovery Room, he should have considered alternatives to Pethidine when that was proving to be ineffective.
- His assessment of [Ms A] when he was called back to the ward was grossly inadequate.
- There were a number of major contraindications to a caudal injection being given at all.[9]
- He did not obtain informed consent for the caudal injection, going ahead with [Ms A] specifically refusing to give consent.[10]

[9] In a subsequent report Dr Sherriff changed this statement. Refer to page 31.
[10] In a subsequent report Dr Sherriff changed this statement. Refer to page 31.

[Dr B's] response to Dr Sherriff's first report

I have cross-referenced my response to the page numbers and paragraph numbers used by Dr Sherriff.

1. Page [19] para [4]
I gave details of postoperative pain management to [Ms A], especially because that was worrying her most. This was not limited to discussing my use of pethidine. I did not 'guarantee' that my methods of anaesthesia would be 100% effective. However I did have reason to be confident that my chosen regime of anaesthesia, in combination with pain relief used intra-operatively by the surgeon [Dr C] would be successful, because of our extensive experience and the lack of complications in the past.

My experience over many years was that similar procedures performed by [Dr C] had not required use of regional block postoperatively, unless it was deemed to be indicated when it was discussed preoperatively and performed at the beginning or at the end of operation before leaving operating room (O.R.).

2. Page [19] para [5]
I inserted a 20G intravenous canula in the right forearm in the pre operative holding area and gave midazolam 1.5mg. through it. That canula size has proven adequate for surgical procedures where large, sudden blood loss is not anticipated.

3. Page [19] para [6]
Anaesthesia was induced with midazolam 2.5mg, inhalation of sevoflurane in oxygen and alfentanil 0.5mg. Endotracheal intubation was achieved with vecuronium 4mg. Ventilation was maintained with a mechanical ventilator. I then switched from sevoflurane to desflurane for maintenance of anaesthesia. Rocephine (ceftrioxone) lG was given. As soon as the anaesthetic was stable I administered Dexamethasone, Ondansetron. Clonidine lSOmcg was started as an infusion soon after. Clonidine potentiates local anaesthetics and analgesics as well as having a sedative effect for a few hours postoperatively. It is used for conscious sedation and for difficult children preoperatively.

4. Page [19] para [7]
In my extensive experience in working with [Dr C] I was aware of his practice of infiltrating incisions and areas through which laparoscopic canulae are inserted with bupivacaine .5% with 1: 200,000 adrenaline. This allows me to only use short acting analgesics intraoperativly (such as alfentanil or remifentanil) as required. Distance from OR to recovery room (RR) for [Ms A's] transfer was about 20 steps. That allows recovery room pain control to be achieved with long acting narcotics given as small boluses intravenously. Having worked in those theatres for up to 3 days a week for over 7 years I know to trust the staff working there and they know my preferences. Hence no long acting analgesic was given intraoperatively. I have convinced myself of the efficacy of this method over at least 3 years or so, by virtue of my experience.

5. Page [19] para [8]
Recovery room. I was called by a nurse who reported that [Ms A] was having pain. I went to see her. She did complain of pain when roused but was then able to fall asleep for a period of time. Therefore I told the nurse to give more pethidine. Given time and with longer periods of consciousness I expected that we could then assess the pain better. It appears from [Ms A's] complaint that she has no recollection of the Recovery Room.

6. Page [19] para [9]
Transfer to single room at 1815 hrs. I had seen [Ms A] in RR at about l730hrs. The nurse called me from the ward at l830hrs and gave me description of localised persistent severe pain in spite of everything that was given intra-operatively and postoperatively. I had been following [Ms A's] progress and knew that a local block would be more likely to relieve localised pain, and that the type of block most easy to administer swiftly where she was would be caudal block. I was able to go to [Ms A] straight away, assess the situation personally and if indeed she was in significant pain, act immediately if the nursing staff had prepared a syringe, needle and local anaesthetic. It was for this reason that I gave instructions for the nurse to prepare for a caudal block over the telephone. This did not mean that I did not intend to assess [Ms A] for myself first.

7. Page [20] para [3]
By the time of my arrival in the room, the nurse had told [Ms A] that I had recommended a caudal block. [Ms A] was concerned about having to receive an injection in the area that was likely to be covered with psoriasis. I was aware that she had questioned the administration of enema as part of bowel preparation when in the preoperative holding area and [Dr C] had allowed that. Therefore I gave [Ms A] a description of the procedure and the reason I felt it was her best option to relieve her level of pain. It was my belief that she understood the situation and the procedure. She did cooperate with me and the nurse when we administered the caudal block.

I acknowledge that there are some details relating to the administration of the caudal block that are not given in [Ms A's] record. With hindsight, given her initial concerns I should have recorded something of the consent, and information given. In terms of her position, I used the standard position for a caudal block and of course standard aseptic precautions and technique and equipment. I perhaps wrongly assumed that the standard techniques and so on that I used were not required to be recorded. (This is different from for example an epidural where there are several commonly accepted ways of performing these and one always did record which was used).

8. Page [20] para [4]
There was no restraint required. The nurse did assist [Ms A] to stay in the left lateral position with her knees pulled up and back supported to prevent [Ms A] from making any sudden movement at the wrong time. The assistance from the nurse was the same as is required for assisting in inserting any spinal central neuraxial block in any other

situation. Although details are not given in contemporaneous notes 'Nurses feedback notes' describe what the nurse did well.

9. Page [20] para [5]
I note Dr Sherriff's comment regarding the differences in the accounts of the insertion of the caudal block. The events I have described are what occurred. I have reviewed the Feedback Report. Obviously I cannot comment on the specific discussion between [Ms A] and the nurse before I arrived however I did expect there to have been a discussion with [Ms A] about a caudal block, as there was. I was also made aware of the amount of pethidine given and the lack of effect on [Ms A's] pain, which she rated as 8/10. I likewise believed [Ms A] understood the caudal block procedure and agreed to this. I have reviewed the nursing records and cannot see any reference to [Ms A] commenting that the caudal block was administered without her consent, or any comments to that effect. I do appreciate that the psoriasis on her buttocks was causing pain.

10. Page [20] Paras [6-9]
No comment in addition to my comment at 9 above.

11. Page [20] para [10]
Dr Sherriff asserts that "it is beyond belief that anyone would consider that [Ms A] had given her informed consent". I do not agree, and this is at odds to Dr Sherriff's later correct comment that it is not for him to judge whose recollection of events is nearer to the truth. Dr Sherriff does correctly record that [Ms A] had no recollection of my consultation with her prior to administering the caudal block. That is not surprising given the medication administered up to that point. I certainly did discuss the procedure with her. I believe that the matters I have described at paragraphs 7 and 8 above should show that [Ms A] was informed as to what the procedure entailed and the reasons for it being offered to her as the most effective and speedy option in the circumstances. That [Ms A] co-operated as observed by me and noted by the nurse indicated to me her acceptance of it.

12. Page [21] para [5]
With the benefit of hindsight it is easy to say that more should have been said to [Ms A] regarding postoperative pain relief. Seeing patients well ahead of operation is ideal but happens only unusually due to the availability of beds, economic considerations and personal convenience of people involved (both patient and doctors). Retention of information given so close to the operation is frequently recognised to be unsatisfactory. Even written information given at the time of booking (the surgeon's information, anaesthetic information and pamphlets and brochures from hospitals) can lead to patients not knowing how much importance to give to various items. I did make it my practice to provide patients with an information booklet which I distributed to surgeons with whom I operated. They then gave the booklet to the patient prior to me seeing them. I assume that this happened in [Ms A's] case.

Most experienced clinicians have a standard plan and plans 'B' or 'C' in their mind. Telling all of this to a patient an hour before surgery when seen and prepared by nurses, surgeon and anaesthetist is of dubious value. What one tells a patient is also dependent on the type of procedure to be undertaken, relevant medical conditions or medical history and the anaesthetist's own experience.

13. Page [21] para [6]
The drugs mentioned are all accepted and commonly employed strategies. Again I believe that it is with the considerable advantage of hindsight that it is reasonable to suggest that spinal/epidural techniques should have been mentioned in discussion and on pre-operation consent for [Ms A] to sign. My usual method did work for common discomforts after a vaginal and laparoscopic procedure. The severity of pain from one drain as [Ms A] experienced was exceptional in my experience.

14. [Consent pages 21-22]
I have made comments on matters raised here elsewhere in my reply.

15. Page [22] paras [8-9]
Clonidine was given by infusion soon after the anaesthetic was stable, as indicated on the anaesthetic chart.

I hope I am allowed to consider that after a career of over 45 years in clinical practice in anaesthetic specialty, I am able to judge that my patient was adequately anaesthetised by clinical observation and supported by stability of vital signs automatically and regularly recorded. I do not consider Dr Sherriff's suggestion that I failed to administer adequate analgesia is fair. [Ms A] did not wake in severe pain. She complained of pain in RR and was given pain relief. She woke after reaching her room. In my view the giving of any particular group of analgesics should not constitute the measure of what is an 'acceptable' standard. A more flexible control of the analgesic component of anaesthetic state can and is achieved with boluses of shorter acting agents as required or infusions of such agents.

Over the last few years I moved towards this method and found it very satisfactory. Prior to that I have, like most of anaesthetists, used morphine, pethidine in pre medication, as part of the anaesthetic mixture (sleep/unconsciousness, analgesia, reflex suppression and relaxation). As more potent shorter acting analgesics became available achieving the ideal of awake, comfortable and stable patients became possible in higher numbers of patients undergoing diverse surgical procedures.

Seeing how [Ms A] responded to fairly substantial dose of pethidine postoperatively one wonders whether a dose of long acting powerful analgesic given intraoperatively would have achieved a different outcome in terms of the level of pain she experienced postoperatively.

[Anaesthetic record Page 22-23]

The monitor generated record and hand written record are on the same time scale. I found that by not having to manually record vital signs I was even more able to concentrate on a patient's behaviour and also that I was better at recording my own actions.

16. [Recovery Room Management Page 23]
I agree that although in theory one narcotic is as good/effective as another sometimes in practice, one is more effective than the other. In the recovery room [Ms A] did rouse from sleep to complain of pain but was not saying how bad or where this pain was; she then went back to sleep. She mentioned the site of the pain after getting to her room. I am confident that if her pain had been so acute at that earlier stage this would have been documented. I have covered elsewhere all other points raised.

17. Page [24 para1-]
I have responded to these points elsewhere. However I wish to add that I am well aware of the College Guidelines regarding major Regional Analgesia and consent once a patient has been administered sedation. This can and does create difficulties in practice. In this case, as in others, I believe it is a matter of clinical judgment as to whether a patient is able to consent to a procedure and competent to understand information given. The corollary of Dr Sherriff's comment is that presumably he must believe that [Ms A] could not consent to an epidural block, either. Any other option I believe would simply have left [Ms A] in distress for significantly longer; I do believe that the caudal block was effective.

[Ms A] herself declined further pethidine from nursing staff in her room specifically so that she would be able to talk to me. On her return to her room she was not drowsy. In no other case have I found my preferred use of drugs to leave a patient insufficiently controlled of their pain in the postoperative period to require anything other than pethidine.

Further advice from Dr Sherriff in light of [Dr B's] response

Supplementary Comments and Modifications to my Report dated 5th August 2007

You have supplied two reports from [Dr B], one in response to your letter dated 16th August and another in response to my report.

I will deal first with the letter, referring to the sections as numbered by [Dr B].

1. Choice of analgesia. [Dr B] describes his strategy for multimodal analgesia in great detail. This apparently worked to his satisfaction in the vast majority of cases and would be regarded as good practice. No regime however is perfect and the problems here, arose when [Dr B's] usual strategy was not effective.

2. Preoperative discussion. [Dr B] is to be congratulated for providing written information to his patients. There is no issue relating to the explanation of the anaesthetic in general. In the light of [Ms A] specific concerns about pain relief there should have been more detailed explanation of his usual strategy and discussion of other options such as regional analgesia.
3. Decision to insert a caudal block. [Dr B] was clearly in a very difficult situation with a postoperative patient on the ward in severe distress. He gives a very detailed account of the procedure and justification for performing it in the ward. The implication is that he disagrees with the Australian and New Zealand College of Anaesthetists Policy Document 'Guidelines for the Management of Major Regional Analgesia'.
4. Not reviewing [Ms A] till 19/10/07. It can be difficult to fit post-anaesthetic visits into a busy schedule of other commitments, and anaesthetists often rely on surgeons and nurses to let them know of any issues. In this case a visit the following day could well have eased the concerns [Ms A] had about her pain management.
5. [Dr B] describes his vast experience of gynaecological anaesthesia over many years and is to be respected for this.

Comments on [Dr B's] response to my report. The numbers refer to the paragraph numbers used by him.

1. [Ms A] and [Dr B] have different recollections of the pre-operative explanation of postoperative pain management.
2. No problem
3. I have no criticism of the conduct of the anaesthetic with the exception of the question of the administration of a long acting opiate analgesic.
4. [Dr B] routinely relied on recovery room nurses to administer long acting narcotics for postoperative pain relief. Without giving such drugs intra-operatively, I am surprised that he did not encounter more patients waking up in pain.
5. It is not surprising that [Ms A] had no recollection of the recovery room. It is not unusual for patients in the recovery room to be drowsy following a general anaesthetic but then complain of severe pain when awake. Pethidine 100mg given over an hour is not an exceptionally large dose especially as no long acting narcotic had been given intra-operatively. Further pethidine or a change to morphine could have been successful.
6. It appears that [Dr B] attended promptly when requested by nursing staff on the ward.
7. [Dr B] gives a much more detailed account of his consultation with [Ms A] prior to the insertion of the caudal than in his original report. It is quite possible that she has little recall of this, due to the residual effects of the general anaesthetic. That however, is difficult to reconcile her graphic description of the injection itself with the accounts of the nurse and [Dr B]. The question of consent for a pain relieving procedure in a patient who is in severe distress is a difficult issue. If there is any

doubt about the ability of the patient to give consent it would be wise to avoid any procedure which is not routine, mainstream practice.

8. 9 and 10. No further comment.
9. Perhaps my wording here is a little strong and should be amended. I will detail this later in this report.
10. Most of the preoperative consultation and consent process was entirely satisfactory. [Ms A's] specific concern was about postoperative analgesia. I am of the firm belief that there should have been some discussion as to the options available if [Dr B's] usual successful strategy did not work as well as expected.
11. No further comment.
12. No further comment.
13. [Dr B] has clearly given considerable thought to his analgesic strategy. It is however, not unusual for patients to wake pain free and then become distressed in recovery as the residual effects of the anaesthetic drugs and short acting analgesics wear off. Opiates given by the recovery nurses do not work instantly. Intra-operative administration of a narcotic will lessen this analgesic gap. This could be viewed as a minor rather than major departure form acceptable standards.
14. No further comment.
15. There were several alternatives to a caudal block that were not considered.
16. [Dr B's] point about consent for a lumbar epidural is valid. That however, does not allow the decision for a caudal with doubtful consent and several contraindications to be condoned.

As I have stated above, [Dr B] was in an unfamiliar and difficult situation and I am sure he was trying to do the best for his patient.

In summary, in the light of the above comments, I would be grateful if the following amendments could be made to my report.

Page [19] para [9] Please change 'beyond belief' to 'difficult to believe'.

Page [21] para [9] Please change 'major' to 'minor'.

In my summary, in the penultimate comment, change '… number of major contraindications …' to '… number of contraindications …'[refer to page 24].

In the last comment change to '… [Ms A] claiming that she specifically refused to give consent.' [refer to page 24].