Error in administration of anaesthetic
(02HDC05291, 18 March 2004)

Anaesthetist ~ Standard of care ~ Medication error ~ Aware under anaesthesia ~ Record-keeping ~Rights 4(1), 4(2)

During the preoperative stages of an admission to a private hospital for a hysterectomy and abdominoplasty, a 39-year-old woman was seen by an anaesthetist. The anaesthetist examined the inside of the patient's right arm in order to administer a sedative. The patient suggested that access to her veins was easier in her left arm, as in the past there had been problems with her right arm. The doctor continued with the procedure, moving himself and his equipment to a better position to access the vein, and made the comment "Who has been in here?", which upset the patient.

Having gained intravenous access, the anaesthestist intended to inject a fast-acting sedative (midazolam). However, he inadvertently picked up the wrong syringe and instead injected a muscle relaxant (vecuronium), which paralysed the patient while she remained awake. Once it became clear that the patient was in trouble she was given oxygen and taken to theatre, where she was intubated and anaesthetised as planned before the surgery commenced. The anaesthetist said that because of the "shock of the incident" he forgot to fill in the clinical record of the drugs he administered preoperatively, or record details of the incident and the actions he took. He also stated that he believed the error occurred because he had moved the tray containing the syringes from its normal position when he changed position to gain venous access.

The patient was also concerned that after the incident the anaesthetist tried to withhold information from her. He visited her three times after the surgery, first on the evening following the operation, when he reassured her that everything had gone satisfactorily and he would speak to her the next day. He returned as intended and explained the incident. He then visited on the day of her discharge, and explained what had happened and apologised. The patient alleged that the doctor's story developed with each visit, and that his apology appeared insincere. An internal investigation was conducted by the hospital.

The anaesthetist was found in breach of Rights 4(1) and 4(2), in not checking the drug to be administered, and failing to meet contemporary standards of record-keeping. In relation to his comment "Who has been in here?", he was reminded of the need for sensitivity when making remarks within hearing of a patient in theatre.

The anaesthetist advised that since the incident he has altered his practice and now labels his syringes, uses different sized syringes for muscle relaxants and sedatives, and no longer takes muscle relaxants into the preoperative area.