Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239

Complaint

The Commissioner received a complaint from a consumer in respect of the services provided by two Orthopaedic Surgeons and an Orthopaedic Registrar.

The first Orthopaedic Surgeon

The complaint against the first Orthopaedic Surgeon is that:

- *The first Orthopaedic Surgeon did not provide services of an appropriate standard during a surgical procedure performed in mid-September 1996 at a private hospital.*
- *The first Orthopaedic Surgeon did not provide post-operative care of an appropriate standard following this surgical procedure.*
- *The first Orthopaedic Surgeon did not diagnose the consumer's spinal tumour.*
- *The first Orthopaedic Surgeon did not fully inform the consumer about the surgical procedure that he performed, the risks involved, or other options open to him.*

The second Orthopaedic Surgeon

The complaint against the second Orthopaedic Surgeon is that:

- *The second Orthopaedic Surgeon did not provide services of an appropriate standard to the consumer while he was in a public Hospital under the Surgeon's care for nine days in mid-September 1996.*
- *The second Orthopaedic Surgeon told the consumer that his condition could not be improved surgically.*
- *The second Orthopaedic Surgeon did not diagnose the consumer's spinal tumour.*
- *The second Orthopaedic Surgeon did not refer the consumer to a Neurologist until requested to do so by the consumer five days after his admission to the public Hospital.*

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Complaint, *continued*

The Orthopaedic Registrar

The complaint against the Orthopaedic Registrar is that:

- *The manner in which the Orthopaedic Registrar informed the consumer of the results of the Magnetic Resonance Imaging (MRI) scan performed at a third Hospital four days after surgery was unacceptable.*
- *The Orthopaedic Registrar woke the consumer at about 9:20pm on that day and informed him that the MRI scan results had been received, it was felt that the consumer's condition was inoperable and there was nothing that could be done. The Orthopaedic Registrar then left.*

Investigation

The Commissioner received the complaint from the consumer on 18 December 1996 and an investigation was undertaken. Information was obtained from:

The Consumer
The Consumer's Wife
The first Orthopaedic Surgeon/Provider
The second Orthopaedic Surgeon/Provider, Public Hospital
The Orthopaedic Registrar/Provider, Public Hospital
The Anaesthetist
The Director of Rehabilitation, Crown Health Enterprise

The Commissioner also obtained the consumer's medical records and obtained advice from an independent orthopaedic surgeon.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation

Background

The consumer was admitted to a private hospital in mid-September 1996 for surgery involving exploration of the lumbar spine and a discectomy. The first Orthopaedic Surgeon performed the surgery. There were a number of complications arising from the operation, in particular the consumer developed Cauda Equina syndrome with epidural haematoma and spinal stenosis at the lumbar ("L") 3-4 and 4-5 levels. (The Cauda Equina is a collection of nerve roots from the lumbar sacral and coccygeal spinal nerves that run down inside the spinal column. Spinal stenosis occurs when the spinal canal narrows resulting in the nerves becoming squashed together.)

In addition the consumer was later found to have developed a tumour of the neurofibroma type at the thoracic ("T") 4 level. It is not clear when this tumour developed.

In order to fully understand the operation which took place on that day and the resulting complications it is necessary to look briefly at the consumer's history.

The consumer had several years' history of lumbar back pain. This pain was intermittent and was generally settled with standard treatment.

In March 1996 the consumer had a fall and bruised his left thigh. Following the fall he was aware of some numbness in his left thigh. He also developed lumbar back pain which increased in severity and more severe pain in his left leg which extended down as far as his ankle.

In late April 1996 the consumer consulted his General Practitioner. The consumer consulted his GP again in mid-May 1996 and at that consultation the GP arranged for the consumer to have an x-ray at a Medical Centre. He also referred the consumer to see the first Orthopaedic Surgeon, who consulted at that Medical Centre.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

Pre-operative Care

The consumer saw the first Orthopaedic Surgeon four days later. Following the consultation the first Orthopaedic Surgeon noted that:

> "*Initial examination showed him to be a somewhat overweight middle aged man. He walked with a very rigid back and a considerable lateral shift was noted in the lumbar spine. Maximal tenderness was to the left of the mid line in the lower lumbar region. He was only able to flex his back about 30 degrees of the vertical and extension and lateral flexion movements to the left were all limited and very painful. Straight leg raising was only 40 degrees on the left with a strongly positive sciatic nerve stretch test, it was only slightly better on the right side perhaps 60 degrees. Knee reflexes were present and equal but I could not detect an ankle reflex on either side. Plantar reflexes were downwards, there was a rather vague and indefinite change to sensation over the S1 nerve dermatome. Peripheral pulses appeared satisfactory. There was a definite area of numbness on the lateral aspect of the left thigh. This extended to just below the knee onto the lateral aspect of the lower leg ... my initial impression was that the patient had an acute disc prolapse and I suggested that we proceed to an epidural injection of steroid to give him some pain relief and also approached ACC for consent for CT scanning at […] Radiology.*"

The consumer subsequently received an epidural injection at a different clinic seven days later. Seven days after this, the consumer had a CT scan at a Radiology clinic. The CT scan report recorded that:

> *"Contiguous scans were taken through the discs at the L3-4, L4-5 and L5-S1. There are generalised annular bulges at L3-4 and L4-5 (quite marked at L4-5) but the CT demonstrates no discrete extrusion or protrusion. No abnormality is seen at L5-S1 and no significant degenerative changes are seen in the posterior joints."*

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

The first Orthopaedic Surgeon advised the Commissioner that the result of the CT scan report and films were too inconclusive to advise the consumer accurately. Accordingly he referred the consumer to have a MRI scan at another private Hospital in mid-July 1996.

The report of the MRI scan indicated that:

> *"Mild degenerative disc changes can be appreciated at L3-4, L4-5 and L5-S1 where there is loss of height from the posterior aspects of the disc spaces and loss of hydration. At L4-5, there is a moderate sized left postero-lateral disc protusion which compresses the dural sac and also demonstrates inferior migration behind the upper end plate of L5. Inferior discent is measured at about 0.5cm. There are no signs of compromise to the emerging L4 nerve roots. No focal disc protrusion is identified at L3-4 nor at L5-S1.*
>
> *Mild degenerative disc change is apparent at T11-12 while the other discs from T12-L3 have appearances which are within normal limits. There are no signs of a focal disc protrusion or nerve root compromise in the upper lumbar spine. No signs of spinal stenosis nor of an intradural mass. The conus has normal appearances.*
>
> *Impression:*
> 1. *Moderate sized left postero-lateral L4-5 disc protrusion with inferior migration and dural sac compression.*
> 2. *Mild degenerative disc change is present in L3-4, L4-5, L5-S1 and T11-12.*"

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

The consumer saw the first Orthopaedic Surgeon for a review at the end of July 1996 after the Surgeon had received the MRI scan report and films. The Surgeon wrote to the consumer's GP at the end of July 1996 and advised that:

> "*The epidural injection of steroid he has been given gave him some relief but the pain is only tolerable if he really does nothing at home at all. Any attempt to do even light physical activities brings on quite severe low back pain and left leg pain. In the circumstances, I think [the consumer] would probably benefit from discectomy at L4-5 level, but I have stressed to him that this will only treat part of the overall problem and that he will not be totally symptom free following this procedure, although it should get rid of his nasty sciatica.*"

The consumer advised the Commissioner that at no stage during the consultation on that day did the first Orthopaedic Surgeon inform him of any risks or dangers associated with the proposed operation.

The consumer received a consent form for the operation in the post from the first private Hospital at the end of August 1996 which he signed and returned five days later. The consent form reads in part:

> *"I,* [consumer's name] *accept the advice of* [the first Orthopaedic Surgeon] *and request treatment. I have received a reasonable explanation of the intent, alternatives, risks, complications and likely outcomes of the anaesthesia and operation/treatment of discectomy and request this to be carried out on myself ... I realise medical practice is not an exact science but I am satisfied that I have been given a sufficiently full explanation of possible outcome."*

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

The Operation

The consumer was admitted to the first private Hospital in mid-September 1996 and underwent surgery for exploration of the lumbar spine and a discectomy. The operation proved to be difficult and various complications ensued. In short, there was excessive bleeding and in addition a cerebrospinal fluid ("CSF") leak occurred. The difficulties encountered were recorded by the first Orthopaedic Surgeon in an operation note as follows:

> "*The operation was difficult because of the abnormal amount of bleeding. Whether this was due to the fact that the man had been taking Disprin, although not in recent days, is uncertain. The anaesthetist had marked problems in obtaining hypotensive anaesthesia despite a very large cocktail of drugs …*
>
> *Findings – Marked adhesions between the spinal cord nerve and a large disc prolapse. These were freed but unfortunately a CSF leak occurred while at the junction of the nerve exiting from the dura.*"

The operation note also recorded that the disc was opened and curetted in the normal manner and a wide decompression hemi laminectomy was performed down the left side. (A laminectory is an operation in which the arches of one or more vertibrae are removed so as to expose a portion of the spinal cord for (among other things) relief of pressure due to disc protrusion.) The first Orthopaedic Surgeon noted that he placed a portion of surgi-cell gauze in the vicinity of the dural leak to encourage a clot formation in an effort to stop any complications of menigocele or CSF fistula developing.

The attendant Anaesthetist advised the Commissioner that well into the surgical procedure the first Orthopaedic Surgeon asked if there was anything she could do to reduce the bleeding as he felt he could not proceed if the bleeding continued.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

She further advised that:

> "*I suggested that he pack the wound while I reduced the patient's B.P. which was about 120/ at that time. By deepening the anaesthetic I was able to get the B.P. to 95/ - 100/, and the operation continued. The dura was entered during the procedure. At the end of the operation the patient was reversed and turned supine, and extubated when his protective reflexes had recovered.*"

Post-operative Care – First Orthopaedic Surgeon

The day after surgery the consumer experienced leg pains and headaches. The consumer advised the Commissioner that the day after that, at his request, the first Orthopaedic Surgeon was called back to see him as the pain was getting worse. He advised that the Surgeon said he would experience discomfort for a few days as there was some scar tissue he had had to go through and there was some bruising. The consumer advised that the following day the Anaesthetist came in to check on him and brought the first Orthopaedic Surgeon, in who said that nothing was wrong and that the pain should go in a few days. The consumer advised that at this stage he was still in pain and his legs were numb.

The medical notes for that day (the third day after surgery) recorded that the consumer was in "incredible pain, lying on his stomach and groaning".

The first Orthopaedic Surgeon advised the Commissioner that he left New Zealand at short notice the same day. He notified the Hospital staff and the consumer that the second Orthopaedic Surgeon would be responsible for the consumer's care. He wrote to the second Orthopaedic Surgeon the same day but did not speak with him until two days later:

> *"As I will be away unexpectedly this week would you please keep an eye on this man for me. He had a discectomy* [three days ago]. *Difficult due to adhesions and there was a small CSF leak. He has had urinary retention problems post-op but it sounds like he had some beforehand as well. He has been very slow on mobilising due to (L) leg numbness. Would you please keep an eye on his progress and he can go home when he can cope."*

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

The first Orthopaedic Surgeon further advised that when he last examined the consumer on that day (three days after surgery) he was very slow to mobilise because of a lack of function in both legs. He stated that "*[the consumer] informed me that he felt his right leg was very weak. He also stated to me that he thought the right leg was improving. Because of this and in the absence of any definite indications to the contrary, I left instructions that the patient was to be mobilised within the limits of his symptoms.*"

The consumer was seen by the Anaesthetist after the first Orthopaedic Surgeon had left. The Anaesthetist was concerned at his state and tried to contact the second Orthopaedic Surgeon. She was unable to contact him and accordingly consulted with the Orthopaedic Surgeon on call at the public Hospital. This Surgeon examined the consumer and noted in the records that there was clearly a Cauda Equina lesion. He then had the consumer transferred by ambulance to the public Hospital at approximately 9pm.

The first Orthopaedic Surgeon's Response

The first Orthopaedic Surgeon advised the Commissioner that he spent considerable time with the consumer and his wife prior to the surgery. He stated that matters were discussed at length during each consultation as options became more limited.

The consumer lodged a claim with ACC in respect of the complications he suffered following the surgery. ACC accepted his claim on the basis of medical mishap and found that the complications suffered were not as a result of a failure on the part of the first Orthopaedic Surgeon to exercise a reasonable degree of care and skill.

Post-operative Care – Orthopaedic Registrar

The consumer advised the Commissioner that four days after surgery he was told that he would be going to a different city later that day for a MRI scan. The consumer asked to see the second Orthopaedic Surgeon but he was not available and instead he was seen by that Surgeon's registrar (the Registrar under investigation), who told him that his problem could be one of three things:

1. A blood clot
2. Damage to the spinal cord
3. Damage to the nerves.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

The consumer stated that "*we [my family were present…] asked him what the outcome of each case would be and he advised that if it was a blood clot an operation could remove this but of the other two he just shrugged his shoulders and said nothing more.*" The consumer then went for the MRI scan and subsequently returned to the first public Hospital. He advised the Commissioner that he "*was woken about approximately 9:15pm by [the Orthopaedic Registrar] to tell me they had the report back from [the] MRI unit, which had been faxed through. He told me that my condition was inoperable and there was nothing they could do"*.

The Orthopaedic Registrar's Response

The Orthopaedic Registrar advised the Commissioner that on that day (four days after the consumer's surgery), at approximately 9pm he was contacted by a radiologist with a verbal (preliminary) report of the MRI scan done that day on the consumer.

The Orthopaedic Registrar further advised that "*I was of the opinion that [the consumer] would appreciate hearing the result as soon as possible, therefore I went to [the ward] soon after 9pm and on entering his room found him to be sleeping. My presence in his room caused him to rouse.*

After ensuring that [the consumer] was fully awake I reiterated to him that there was no indication for urgent surgery and that the medical team would discuss subsequent management with him in the morning. After our discussion I believed [the consumer] understood what was said and thought that he had no concerns which needed addressing at that time, therefore I took my leave." The clinical notes made by the Orthopaedic Registrar record that there was to be no surgical intervention that night.

A preliminary report on the MRI scan was hand written by the Orthopaedic Registrar in the clinical notes on that day (four days after surgery) and stated:

> "*Tight stenosis L3-4 level form Haematoma posteriorly and anterior annular bulge. Lower down oedema. No residual disc L4-5.*"

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

The written report concluded that there was a definite stenosis of the theca at the L3-4 level by what appeared to be a recent haematoma. No other significant abnormality was detected.

Post-operative Care – Second Orthopaedic Surgeon

The consumer advised the Commissioner that the following day (five days after surgery) he was told by a nurse he was being treated for paraplegia and it was hoped that the blood clot would dissolve but it was possibly a matter of two years or more, if at all. The consumer also advised that his wife was visited by a social worker who informed her that when needed, they would look at providing ramps and rails for wheelchair access at their home.

The second Orthopaedic Surgeon advised that on that day, after considerable discussion between himself and the on-call Surgeon, it was decided that a conservative approach would be best for the consumer and that the consumer was informed of this accordingly.

The second Orthopaedic Surgeon advised the Commissioner that the consumer was seen daily by the Orthopaedic Team and every day, except the sixth day after surgery, by him. He stated that there was evidence of neurological improvement during this period.

Eight days after surgery the consumer requested a neurological opinion. This request was agreed to by the second Orthopaedic Surgeon and a neurological opinion was requested. The second Orthopaedic Surgeon advised the Commissioner that he discussed the consumer's condition further with the on call Surgeon and it was again agreed that a conservative attitude should be maintained.

Three days later the on-call Surgeon and the second Orthopaedic Surgeon reviewed the results of the MRI scan which had been taken four days after surgery as well as the consumer's current condition. The second Orthopaedic Surgeon advised the Commissioner that there was an improvement in the consumer's neurological condition. It was agreed that a conservative attitude would remain appropriate, but a further MRI scan should be obtained to assess the current position.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

Later that morning the consumer saw a Neurologist, at the public Hospital. The Neurologist noted that "*since the operation [the consumer] has had pain from buttocks radiating down to the ankles. The weakness of the legs has not improved appreciably, and he remains unable to pass urine. He had a bowel motion yesterday and feels that he had good control.*" The Neurologist also found impaired sensation extending up to the T9 level. He concluded: "*the sensory loss is much higher, and suggests a mid thoracic cord lesion in addition to the Cauda Equina type picture. I wonder if the basis for this is ischaemia. Suggest MRI up to mid thoracic.*"

Following the consultation with the Neurologist, the consumer was taken for a third MRI scan at approximately 7pm (now eleven days after surgery). The preliminary report of the scan was recorded in the clinical notes:

> *"Preliminary report – no deterioration in lumbar region. Still considerable deformity of theca at L4-5 level, but less at L3-4. The scans of the upper spine show what appears to be a localised subdural/epidural abscess compressing the cord at T4-T5 level. Collection is posterolaterally on the right. Discussed with [the second Orthopaedic Surgeon] – referred for neurosurgical admission."*

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

The Locum Neurosurgeon ("the Locum") at the second public Hospital reviewed the MRI scan report and the consumer that evening. He noted that the consumer had a severe Cauda Equina syndrome. This appeared to be primarily caused by compression of the secal sac from spinos tenosis and epidural haematoma at L4-5. In addition, the Locum noted that in the thoracic spine at T4-5 there was an epidural mass which appeared to be cystic in nature. This mass was causing moderate cord compression. The Locum determined that urgent surgery was required in order to decompress the Cauda Equina. In addition surgery was undertaken to explore the thoracic region and remove the mass which had been noted at the T4-5 level. In his operation note the Locum recorded that the consumer had "extremely severe compression of the dural sac at L4-5 and to a slightly lesser extent at L3-4". The Locum performed a complete left L4 hemi laminectomy and removed the epidural mass. He noted that the defect in the dura was so large that it could not be repaired directly. In addition the Locum explored the L5 nerve root on the left but noted that it was severely traumatised by the previous surgical procedure (mid-September 1996) and there was nothing further that could be done after he had decompressed it satisfactorily.

A Neurosurgical Registrar performed surgery to remove the tumour which had been noted at the T4-5 levels. In the operation note this Registrar recorded that the tumour probably arose from the right T4 nerve root.

The consumer remained in the second public Hospital until mid-October 1996 when he was transferred to a third public Hospital.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

The second Orthopaedic Surgeon's Response

The second Orthopaedic Surgeon advised the Commissioner that there are a number of issues to consider with respect to diagnosing the consumer's spinal tumour.

He noted that these are:

1. A histopathology report showed that the tumour was a small neurofibroma, which is a non-cancerous abnormal growth, involving the right T4 nerve root. It was a small benign lesion.
2. The neurofibroma was a chance finding during the second surgery (eleven days after the first procedure). It was not diagnosed by the Neurologist, nor picked up by any of the three previous MRI scans, and it was only when surgery was carried out for what was thought to be an epidural abscess that further exploration of the thoracic spine showed the small neurofibroma in the right T4 nerve root.
3. The neurofibroma played no part in the consumer's lower limb problems. It was agreed by the Neurologist in discussions, and the Neurosurgical team in correspondence, that the lower limb problems were not a reflection of the tumour which was in the thoracic region.
4. The Neurologist had not anticipated any lesion at T4.

The second Orthopaedic Surgeon advised that he spoke to the MRI radiologist prior to the consumer undergoing neurosurgery in the second public hospital. The radiologist commented that there was evidence of the lumbar problem resolving, but his concern was what appeared to be an epidural abscess at T4-5. The second Orthopaedic Surgeon told the Radiologist that this did not appear to be consistent with the consumer's condition, and that was when a neurosurgical opinion was requested.

With respect to the consumer's complaint that the second Orthopaedic Surgeon told the consumer that his condition could not be improved surgically, the second Orthopaedic Surgeon responded as follows:
"[The consumer] was told that in my opinion, after review of all the information available and discussion with my colleagues, that [his] best chance of the best long term result, with the least risk of aggravating the problem and perhaps converting a situation capable of spontaneous resolution into a permanent problem was to maintain a non-operative approach.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Outcome of Investigation, *continued*

This decision was not taken lightly. The options of surgical versus conservative management were discussed with [the on call Surgeon] on the Monday, and then again when we reviewed the MRI scan on the Tuesday. There was a further discussion with [the on call Surgeon] at the end of the week, and again in the Ward on the [Monday morning] when we again went over the MRI scan.

Throughout that time our opinion remained that [the consumer's] best chance lay with a conservative approach.

This opinion was based on a number of factors:

1. *The length of time that had elapsed between the event and the presentation at [the first public Hospital].*
2. *That all reports indicated that there had been a very severe bleeding problem at the time of the operation. It was felt that further surgery may only precipitate major problems. Haematological investigations were requested to assess the possibility of coagulation or bleeding defect.*
3. *There was evidence of nerve root damage, which would not be improved by surgery, and the possibility of a vascular phenomena, which again would not be improved by surgery.*
4. *The belief that if the picture was being complicated by the haematoma, then this problem should resolve with the need for surgery.*

In my opinion this approach was supported by further events:

1. *The evidence of progressive recovery of neurological function. [The consumer] regained bowel sensation and it was planned that on his return from the second MRI the catheter would be removed as it was felt he had also probably regained bladder sensation.*
2. *The subsequent MRI [eleven days after the first surgery] demonstrated evidence of the haematoma resolving and evidence of lessening of the stenosis.*
3. *[…The] Consultant Neurologist was of the opinion that the most likely cause of [the consumer's] lower limb problems was vascular in origin, and not a reflection of the haematoma."*

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Advice to Commissioner

The Commissioner's advisor was an independent orthopaedic surgeon who commented as follows:

The Operation

The fact that the operation was technically difficult does not in any way reflect on the skill of the first Orthopaedic Surgeon. Even the most experienced surgeons carrying out this type of operation have difficulty, such as was experienced in this case, from time to time.

The Transfer of Care

The Commissioner's advisor noted with respect to the transfer of care from the first to the second Orthopaedic Surgeon that the transfer was deficient in that "[The first Orthopaedic Surgeon] *did not make entries in the records which would allow someone else to take over the management of the case in his absence … it would be reasonable to expect him to examine the patient in some detail particularly as he was going away and to record the findings so that those continuing his care would be appraised of* [the first Orthopaedic Surgeon's] *assessment before he went away*."

Cauda Equina Syndrome

The diagnosis of Cauda Equina syndrome should have been made by the first Orthopaedic Surgeon two days after the surgery. As a generalisation, an orthopaedic surgeon would be more likely to make that diagnosis than an anaesthetist particularly as he would be aware that Cauda Equina syndrome may be caused by a disc prolapse. The first Orthopaedic Surgeon ought to have read the nursing notes so that he was aware of the entries, as the information provided by the nursing notes is often very helpful in assessing a patient's progress.

Diagnosis of the Spinal Tumour

The spinal tumour was discovered during surgery eleven days after the first procedure.

The pre-operative diagnosis made by the first Orthopaedic Surgeon correlated to the findings from the x-rays taken in mid-May 1996, the CT scan in early June 1996, and the MRI scan in mid-July 1996. There were no findings on examination nor suggested by history, of a tumour higher in the spine.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Advice to Commissioner *continued*

The second Orthopaedic Surgeon's initial decision not to proceed with surgery was prudent.

Referral to a Neurologist

With respect to the consumer's complaint that the second Orthopaedic Surgeon did not refer him to a neurologist until requested to do so by the consumer:

> "*On* [the Monday four days after the first surgery], *when [the consumer] was first seen, the question of Neurological opinion was discussed within the Orthopaedic Team, and it was agreed that there would be no advantage in the management of the case in requesting a Neurological opinion at that stage. Urological opinion was requested and acute Pain Service opinion requested.*
>
> *This opinion was maintained in discussion the following day after review of the MRI scan.*
>
> *...my policy regarding opinion from other specialists is:*
>
> 1. *I have no hesitation in requesting opinion if I feel that opinion is going to facilitate either diagnosis, or, more commonly, determine a particular line of management.*
> 2. *Either my Registrar or House Surgeons are at liberty to request opinion if they feel that this is indicated and I cannot [sic] be contacted immediately for discussion.*
> 3. *If a patient requests a further opinion, that request for opinion is immediately acceded to.*
>
> *This was the situation that pertained in relation to [the consumer's] management."*

As the diagnosis of Cauda Equina syndrome is one which is within the capabilities of an orthopaedic surgeon my advisor was not critical that the opinion of a neurologist was not obtained.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Code of Health and Disability Services Consumers' Rights

The following Rights are applicable to this case:

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 5
Right to Effective Communication

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –…

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option;

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Code of Health and Disability Services Consumers' Rights, *continued*

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.

Opinion: No Breach, First Orthopaedic Surgeon

Standard of Surgical Procedure

In my opinion the first Orthopaedic Surgeon did not breach Right 4(2) of the Code in respect of the surgical procedure he carried out. I accept that the operation was technically difficult and do not consider that the side effects of the operation were as a result of the first Orthopaedic Surgeon not meeting an appropriate standard.

Diagnosis of Spinal Tumour

In my opinion the first Orthopaedic Surgeon did not breach Right 4(2) of the Code by failing to diagnose the spinal tumour. The spinal tumour was a neurofibroma at the T4-5 level. The medical notes indicate that the presence of this tumour did not contribute to the initial symptoms experienced by the consumer, nor to the Cauda Equina syndrome.

Further, the tumour was demonstrated on the MRI scan dated eleven days after the first surgery only as an incidental finding. It did not show on the previous MRI scan dated mid-July 1996 which the first Orthopaedic Surgeon reviewed.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Opinion: Breach, First Orthopaedic Surgeon

In my opinion the first Orthopaedic Surgeon breached Rights 4(2), 4(5), 6(1)(b) and 7(1) of the Code as follows:

Standard of Post-operative Care

Right 4(2)

The evidence obtained demonstrates the first Orthopaedic Surgeon failed to diagnose that the consumer had developed Cauda Equina syndrome. In my opinion the first Orthopaedic Surgeon should have made this diagnosis and in failing to do so did not meet the professional standard required.

Right 4(5)

Further, while it was appropriate for the first Orthopaedic Surgeon to pass on the care of the consumer to a colleague, in my opinion he did not make sufficient entries in the medical records to enable the second Orthopaedic Surgeon to take over the management of the consumer in his absence in the most efficient way. I saw no evidence that the first Orthopaedic Surgeon made a detailed examination of the consumer so that those continuing his care would be fully appraised of his assessment before he went away.

Insufficient Information

Right 6(1)(b) and Right 7(1)

In my opinion the first Orthopaedic Surgeon did not fully inform the consumer about the surgical procedure that he performed in mid-September 1996 and therefore the consumer was unable to give informed consent. I agree that the consumer signed a consent form which was sent out to him by the first private Hospital. The form indicated that the consumer had received from the first Orthopaedic Surgeon a "*reasonable explanation of the intent, alternatives, risks, complications and likely outcomes of the anaesthesia and operation/treatment of discectomy*".

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Opinion: Breach, First Orthopaedic Surgeon, *continued*

Spinal surgery carries with it certain risks. The first Orthopaedic Surgeon should have taken the time to explain the possible risks to the consumer and I have not seen any evidence that he did so. While the correspondence exchanged between the first Orthopaedic Surgeon and the consumer's general practitioner shows that the spinal condition and the option of surgical treatment was discussed, it is insufficient to post a consent form out in the mail and require it to be signed and returned without the patient being fully informed prior to receiving the form. In my opinion the first Orthopaedic Surgeon breached Rights 6(1)(b) and 7(1) of the Code.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Opinion: No Breach, Second Orthopaedic Surgeon

Appropriate Standards of Care

In my opinion the second Orthopaedic Surgeon provided adequate post-operative care and did not breach Right 4(2). The second Orthopaedic Surgeon was justified in deciding not to undertake further surgical procedures. Once Cauda Equina syndrome develops, a MRI scan is the appropriate further investigation, as in some cases the syndrome may occur as a result of the displacement of a disc fragment which had not been removed at operation. Accordingly, any further surgical exploration should only have been undertaken after very careful consideration, recognising that further bleeding was likely and there was the possibility that this could not be controlled. In addition, there was a risk that the dural tear could be made worse. The second Orthopaedic Surgeon requested a MRI scan four days after the first surgery, which was the day after he took over management of the consumer's case.

Failure to Diagnose Spinal Tumour

In my opinion the second Orthopaedic Surgeon did not breach the Code by failing to diagnose the spinal tumour. The spinal tumour was a neurofibroma at the T4-5 level. The medical notes indicate that the presence of this tumour did not contribute to the initial symptoms experienced by the consumer, nor to the Cauda Equina syndrome. Further, the tumour was demonstrated on the MRI scan dated eleven days after surgery only as an incidental finding. It did not show on the previous MRI scans dated mid-July 1996 and mid-September 1996 which the second Orthopaedic Surgeon reviewed.

Lack of Referral to a Neurologist

In my opinion the second Orthopaedic Surgeon did not breach Right 4(5). When the consumer requested to see a Neurologist eight days after surgery the second Orthopaedic Surgeon acceded immediately to the request and referred him to see the Neurologist. Prior to this, the second Orthopaedic Surgeon had diagnosed the consumer with Cauda Equina Syndrome and had monitored him accordingly.

Continued on next page

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Opinion: No Breach, Orthopaedic Registrar

Communication and Information

In my opinion the Orthopaedic Registrar did not breach Right 5 or Right 6(1) of the Code. I have not seen sufficient information indicating the Orthopaedic Registrar told the consumer his condition was inoperable. The clinical notes made by the Orthopaedic Registrar four days after the first surgery indicate that the Orthopaedic Registrar advised the consumer that there was no need for surgical intervention that night, not that he said his condition was inoperable.

Further, I accept the Orthopaedic Registrar's account of the way in which the information was communicated.

Orthopaedic Surgeons, Orthopaedic Registrar

Report on Opinion - Case 96HDC3239, continued

Actions: First Orthopaedic Surgeon

I recommend that the first Orthopaedic Surgeon takes the following actions:

- Apologises in writing to the consumer for breaching the Code, namely his failure to fully inform the consumer of the risks involved with the surgery, his failure to diagnose Cauda Equina syndrome and for the manner in which he arranged the transfer of care to the second Orthopaedic Surgeon. The apology is to be sent to my office and I will forward it to the consumer.
- Liaises with the Royal Australasian College of Surgeons to attend appropriate educational courses to update himself in his profession.
- Establishes procedures for transferring the care of critically ill patients and patients recovering from surgery. A standard procedure should be in place which ensures the efficient transfer of the appropriate information required by the person taking over the care of a patient.
- Reads the Commissioner's paper dated May 1999 on the informed consent process which is enclosed.

Other Actions

A copy of this opinion will be sent to the Crown Health Enterprise responsible for the first public Hospital, the Medical Council of New Zealand and the Chairman of the New Zealand Committee of the Royal Australasian College of Surgeons.

The Commissioner requests the College discusses a relevant educational course to improve the first Orthopaedic Surgeon's knowledge in diagnosing, communicating, and providing appropriate transferral information. The College should consider whether it is appropriate to suspend the first Orthopaedic Surgeon's Fellowship until these educational requirements are met.

The Commissioner also requests this opinion, with names removed, is published for educational purposes.