Informed consent for acupuncture and delayed recognition of pneumothorax symptoms
(**15HDC00947, 19 June 2017**)

Physiotherapist ~ Physiotherapy clinic ~ Acupuncture ~ Informed consent ~ Recognition of symptoms ~ Rights 6(1), 7(1), 4(4)

A woman had been seeing a physiotherapist for physiotherapy treatment for her scoliosis. At her third visit, the physiotherapist asked the woman whether she was "open to acupuncture". The woman said she was.

The physiotherapist's documentation does not record whether adverse reactions were discussed prior to her gaining the woman's consent, or whether the increased risks the woman's scoliosis presented to the situation were discussed, and what safety-netting advice, if any, was provided to the woman for when she left the clinic.

Immediately after the appointment the woman felt light-headed and began shaking. A few hours later she was in "extreme" pain on the left side of her chest. She called the clinic reporting right ribcage pain with breathing, and pins and needles into the left arm, and also complained of being short of breath.

The physiotherapist rang the woman back shortly after. The physiotherapist told HDC that the woman's symptoms were "not shortness of breath but pain on inhalation", and that the woman complained of "pain in the chest, referred symptoms of 'pins and needles' in the left arm and an inability to take a deep breath". The physiotherapist told HDC that she specifically asked the woman whether she was experiencing shortness of breath or dyspnoea, and that the woman told her that her symptoms were "more, 'unable to take a deep breath'". The physiotherapist told the woman that her symptoms were "normal, as it was the muscles tightening back up". The woman was given a follow-up appointment for an assessment the following day.

After the telephone call, the physiotherapist carried out some research into acupuncture-induced pneumothorax (collapsed lung) and sent a text message advising the woman to go to the hospital if her symptoms worsened. The woman was already at the hospital when she received the text.

It was discovered that the woman had a a pneumothorax at the site where the acupuncture needle had been placed. She had experienced a 30% collapse of the lung.

It was held that the physiotherapist failed to provide the woman with information that a reasonable consumer, in the woman's circumstances, would expect to receive. Accordingly, the physiotherapist was found to have breached Right 6(1). Without this information, the woman was also not in a position to make an informed choice, and give her informed consent to having acupuncture. Accordingly, the physiotherapist was also found to have breached Right 7(1).

It was further found that the woman's reported symptoms of "unable to take a deep breath" should have raised concern that a pneumothorax might be present. By failing to turn her mind to this at the time of her initial telephone conversation with the woman, the physiotherapist failed to provide services in a manner that minimised the potential harm to the woman. Accordingly, it was found that the physiotherapist breached Right 4(4).

In addition, adverse comment was made that it appeared that the physiotherapist did not consider the woman's scoliosis adequately prior to performing trigger point needling in this area. Criticism was also made that she did not complete an incident report form immediately on learning of the woman's adverse outcome. It was over a week before the incident was formally documented.

It was also found that there were learnings from this case for the clinic. It was recommended that the clinic should review its current policies and procedures, in particular, its policies relating to timeframes when there are reportable events.

It was recommended that the physiotherapist undertake further education and training on informed consent, review her practice in light of this report, including her process for obtaining informed consent, and provide a written apology to the woman.