Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Complaint

On 29 January 2008, a woman was admitted to a private hospital for an elective repair of her right rotator cuff (shoulder). The anaesthetist administered an interscalene nerve block and proceeded to induce general anaesthesia. The woman developed a severe anaphylactoid reaction and had to be resuscitated. She believes she reacted to Propofol and maintains that the anaesthetist had been given, or had access to, sufficient information to know that she should not have been given this drug. The woman also considers that subsequently she was held largely responsible for not having provided more information at the time of her admission.

Parties

Mrs A	Consumer/Complainant
Dr B	Provider/Anaesthetist
Ms C	Registered nurse
Ms D	Nurse manager
Dr E	Surgeon
A private hospital	Provider/Private hospital

HDC investigation

The following issues were identified for investigation

- the appropriateness of care provided by Dr B to Mrs A on 29 January 2008
- the adequacy of the information provided by Dr B to Mrs A on 29 January 2008
- the appropriateness of care provided by the private hospital to Mrs A on 29 January 2008
- the adequacy of the information provided by the private hospital to Mrs A on 29 January 2008.

Independent expert advice was obtained from anaesthetist Dr David Chamley.

Summary of events

Mrs A was admitted to the private hospital at 7am on 29 January 2008 for an elective repair of her right rotator cuff. She had completed a pre-admission form on which she indicated a previous allergic reaction to Omnopon, with the type of reaction noted as "Anaphylactoid — Severe rash. Carry anaesthetic reaction letter." Omnopon use has now been discontinued but its major constituent is morphine. The admitting nurse, Ms C, elicited further information about a possible allergy to Fentanyl, and added "?Fentanyl" to the form. She highlighted this section with an allergy sticker. In the "Pre-op Care" section of the patient checklist there was an allergy sticker with "Omnopon Anaphylactoid — severe rash" noted. A further allergy sticker was put on the drug prescription chart with "Omnopon" and "?Fentanyl" written below. Mrs A asked whether her husband, who was still with her at this time, should return home to get the letter that she usually carried with her, about previous reactions. RN Ms C replied that Dr B would ask for this if needed.

The surgeon scheduled to operate on Mrs A was Dr E. Dr B said she had not worked with Dr E on a regular basis and they had not had the preoperative discussion that she usually has with surgeons she works with regularly.

The anaesthetic consent form was completed by Dr B. She noted the allergies to Omnopon and possibly Fentanyl and elicited a further probable allergy to non-steroidal anti-inflammatory drugs such as Voltaren. In the summary section Dr B wrote, "Fit for GA + interscalene block pre-op." The tick boxes for "Risks discussed" and "Anaesthesia discussed" were left blank. There was nothing recorded under "Discussion on Risks and Options". The form was signed by Dr B and Mrs A.

Mrs A had a further discussion with Dr B about the letter. She again offered to ask her husband to bring it to the hospital, but Dr B declined. Prior to this discussion, Mrs A thought that the private hospital would have accessed her records from the public hospital, where she had previously had multiple surgical admissions. (Mrs A also has a Medic Alert bracelet but did not wear or take this to the hospital.)

At approximately 10.40am, Mrs A was taken into theatre and an interscalene block was inserted. This was later noted by Dr B in the progress notes to have been "easy and straightforward". However, Mrs A felt the first dose go across her chest and up the right side of her neck, rather than down her arm as she had expected. She felt the second dose go down her arm. She thought that her heart rate had slowed down but ECG monitoring did not indicate this. At around 11.10am general anaesthesia was induced with Midazolam, Propofol, rocuronium and morphine. Mrs A had an anaphylactoid reaction, with bronchospasm and hypotension. Emergency treatment was provided successfully. Dr B contacted the public hospital at about midday and arrangements were made for Mrs A to be transferred to ICU for stabilization and further monitoring. Mrs A was subsequently admitted to ICU at 1.00pm. Her condition was monitored overnight and she was discharged home the following day.

Dr B's progress notes recording the events state: "Transfer to ICU after anaphylaxis response probably to morphine. History of anaphylaxis to Omnopon and severe rash with Fentanyl. Also asthma (severe) with Voltaren."

Later events
On 30 January 2008, Mrs A's daughter lodged a complaint with the private hospital. On 4 February 2008, Mrs A and a patient advocate met with Dr B and Ms D (Nurse Manager) to discuss the incident and the complaint. At the meeting, Dr B confirmed that she had spoken to Mrs A at the public hospital several hours after she was admitted there and offered an apology for what had happened. On 25 March 2008, HDC received a complaint from Mrs A. Information was requested from and provided by Dr B and the private hospital.

Dr B's response

In her response Dr B stated:

> "[Mrs A], by her demeanour and history — gave the impression all necessary information had been disclosed and that the letter from a past anaesthetist left at home simply outlined a reaction to Omnopon over 30 years ago."

Dr B was unprepared for the degree of atopy documented in Mrs A's public hospital notes. Had she known the complexity of Mrs A's allergies, Dr B would have deferred surgery and insisted that it be done at the public hospital, where there were intensive care facilities available.

With reference to her decision to administer morphine, Dr B stated that true morphine allergy is extremely rare and that Omnopon was discontinued many years ago due mainly to adverse reactions to its non-morphine alkaloid constituents. She weighed up other options but as Mrs A seemed definitely allergic to her other preferred options, and based on what she believed from her past teachings, she chose to use morphine.

Associate Professor Galletly[1] also noted that true morphine allergy is extremely rare but that mild anaphylactic reactions to morphine, and in particular Omnopon, are very common and generally harmless. He considers that on the balance of probabilities Dr B would have believed, as he would, that given the history presented, the likelihood of true allergy to morphine was extremely low. The mechanism and the causative agent(s) of Mrs A's reactions during anaesthesia are still not known.

Dr B advised HDC that it is her practice and reputation to decline to anaesthetise patients when matters of concern arise, and that she has a low threshold for taking the unpopular step of declining to anaesthetise patients. She also notes that systemic issues contributed to these events, particularly in relation to the availability of patient notes.

[1] Dr B submitted expert advice from Associate Professor Duncan Galletly with her response to HDC.

The private hospital's response

The private hospital accepted that nursing staff should have acted on the information written on Mrs A's admission form about the anaesthetist's letter and they should have requested a copy of this prior to her admission. However, the private hospital submitted that Mrs A needs to take some responsibility for failing to provide the hospital with accurate information regarding the seriousness of her drug reactions.

The private hospital provided details of several changes that have been implemented as a result of this incident:

- Action taken to set up an arrangement between the District Health Board and the private hospital for access to patient information in a timely manner.
- Nursing staff to check pre-admission questionnaires. Patients to be contacted and anaesthetists notified if concerns are identified.
- Information added to patient information booklet.
- Coloured identification bracelets introduced for patients who have drug allergies or other relevant history.
- Anaphylaxis policy reviewed with minor addition of a blood test.
- Adrenaline minijets introduced in both operating theatres and on the emergency trolley.
- Theatre time-out policy drafted for introduction.
- Patient pre-admission questionnaire altered to include questions about Medic Alert bracelets and descriptions of drug reactions.

The private hospital also apologised for the concern and distress this incident caused Mrs A.

HDC expert advice

Dr Chamley's main concern relates to Dr B's choice of anaesthesia.

Dr Chamley states that the administration of the interscalene block was a standard technique, properly and correctly performed. He notes that the symptoms experienced by Mrs A were consistent with those that may unintentionally be produced during this procedure. Dr Chamley also considers that Dr B's response to Mrs A's unexpected reaction was prompt, effective and of a high standard.

Dr Chamley agrees with Professor Galletly that the mechanism and causative agent(s) of Mrs A's reaction are not known, but adds that while these issues are important for her future medical care, they are irrelevant for the purposes of this investigation. Dr Chamley states that under the circumstances that pertained, the decision to administer morphine did not indicate an appropriate standard of care. In reaching this conclusion he considers the urgency of the procedure, the information available to Dr B about the severity and the nature of Mrs A's reaction, the decision not to wait for Mrs A's husband to bring the letter regarding her reaction, and the availability of alternative drugs.

Dr Chamley discusses the difficulties arising from the use of the word "anaphylactoid" and states that the use of this word by non-medical practitioners should be treated with considerable care. He adds:

> "To assume a mechanism of reaction from the lay use of the word is cavalier. All that can really be taken from the word used by a lay person is that it indicates a severe, or serious, adverse reaction, and more information or considerable caution is required."

Dr Chamley does not raise any concerns about the information Dr B provided to Mrs A, the documentation, or the appropriateness of the decision to anaesthetise her in a private hospital with no ICU/HDU facilities.

Dr Chamley states that the standard of care the private hospital provided to Mrs A, and the documentation, appear to have been appropriate. He considers the changes that have since been made by the private hospital appear reasonable. He also notes that the degree of information sharing that occurs on a routine basis between health providers in New Zealand may not be as great as Mrs A expects.

HDC decision — Dr B — Breach Right 4(1)

Appropriateness of care
I agree with my expert that what is important is what was known by Dr B about Mrs A's drug allergies on the morning of 29 January 2008. I endorse my expert's view that the actual trigger for Mrs A's reaction is irrelevant for the purposes of this investigation. Dr B knew that Mrs A had had a previous reaction to Omnopon and that the main constituent of this was morphine. There was sufficient indication for Dr B to realise that if she wanted to proceed using morphine, more detailed information about Mrs A's allergies and previous reactions was required.

The procedure was not needed as a matter of urgency. Delaying it in order to obtain further information may have been inconvenient, but it did not constitute a risk to Mrs A's health.

I accept Associate Professor Galletly's view that given the complexity of Mrs A's documented history and that the cause and mechanism of her reaction remain unknown, an adverse reaction may have resulted even if Dr B had accessed Mrs A's medical history. However, I see that Associate Professor Galletly himself notes (at para 15 of his advice) that he would "debate" whether Dr B's standard of care fell below that expected of a specialist anaesthetist.

For these reasons I conclude that Dr B did not demonstrate sufficient care and skill in her intervention with Mrs A, and breached Right 4(1) of the Code.

Adequacy of information
I am satisfied that the information Dr B provided to Mrs A prior to the procedure was adequate. Although Mrs A's experience of the interscalene block was not as she expected, Dr B's explanations of the operation and recovery were very thorough.

Conclusion
This case highlights the importance for all anaesthetists, in particular Dr B, of declining to anaesthetise a patient when there are obvious "red flags" about the patient's allergy history, and the procedure is not urgent. The procedure should be postponed in such circumstances despite the possible disappointment to the patient and the necessary disruption for the surgical team.

Actions taken
I note that Dr B has previously apologised to Mrs A, and that the case was reviewed by Dr B with departmental colleagues.

HDC decision — The private hospital — No breach

On balance, I am satisfied that the private hospital provided Mrs A with appropriate care and adequate information. Nevertheless, what happened clearly highlighted several areas in which practice could be improved upon and systems enhanced. I am pleased to see that these have been recognised and acted upon.

Follow-up actions

- A copy of this report will be sent to the Australian and NZ College of Anaesthetists and the NZ Private Surgical Hospitals Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.