Coroner recommends better communication between surgical professionals in complex surgery cases

Key messages from the case

The death of a patient after dental surgery prompted the coroner to call for changes to improve consideration of and communication about anaesthetic risks in surgery.

Details of the decision

Ms F was to have radiation treatment to a large tumour at the base of her tongue. In preparation for this procedure she needed surgery to remove four teeth. As well as the tumour that was obstructing her breathing, she had a number of comorbidities and was anxious and frail.

The radiation treatment was considered time-sensitive, which meant there was some urgency to complete the dental surgery before elective lists closed down over Christmas.

The first attempt at the procedure under general anaesthetic was abandoned because of airway difficulties. A second operation was attempted the next day using local anaesthetic and sedation.

During the procedure, Ms F's breathing became obstructed and she went into cardiac arrest. She was resuscitated but died in hospital nine days later.

Communication between surgical team

The inquest looked at the communication between anaesthetists and surgical team. It was suggested that in this case the two groups had operated 'in two separate tribes', rather than collaborating to achieve the best outcome for the patient.

Informed consent

The second surgery was considered even higher risk than the first because the first attempt would have irritated the tumour and created a greater chance of obstruction. Experts, and the coroner, were critical of the fact that Ms F appeared to have been rushed into this surgery with little time to consider or discuss with her family.

It appeared that no-one had discussed with her the risk that she might die during the surgery.

Experts also suggested that alternatives to the surgery appeared not to have been considered – such as commencing radiation before the teeth extraction, or keeping Ms F awake for the teeth extraction.

In the jurisdiction at the time there was no requirement for separate anaesthetic consent. Experts recommended this as it would ensure that both surgical and anaesthetic risks were appropriately discussed with the patient.

Medical records

The coroner also noted that it was 'very unsatisfactory' that data from the monitoring equipment had been printed out following the procedure and the printout had been lost. The original data was no longer retrievable.

Outcome

The coroner recommended that anaesthetists be involved earlier in the planning of complex surgeries to ensure specific anaesthetic risks were considered.

She also recommended that a separate anaesthetic consent form be considered in complex matters so that treating teams were prompted to consider specific anaesthetic risks prior to surgery.

She recommended the hospital ensure an appropriate system was established to store the data from the monitoring equipment electronically.

Key lessons

Appropriate informed consent means consent to all material risks of surgery – including anaesthetic risks.

In all cases except medical emergencies where a patient is unable to consent at the time, informed patient consent is required. Even where there is some urgency to undertake the procedure, it is important that patients have all the information and as much time as possible to consider it.

References and further reading

- Avant eLearning – Consent: informed consent and more
- Avant factsheet – Consent: the essentials

For more information or immediate medico-legal advice, call us on 1800 128 268, 24/7 in emergencies.
avant.org.au/mlas

avant.org.au/avant-learning-centre