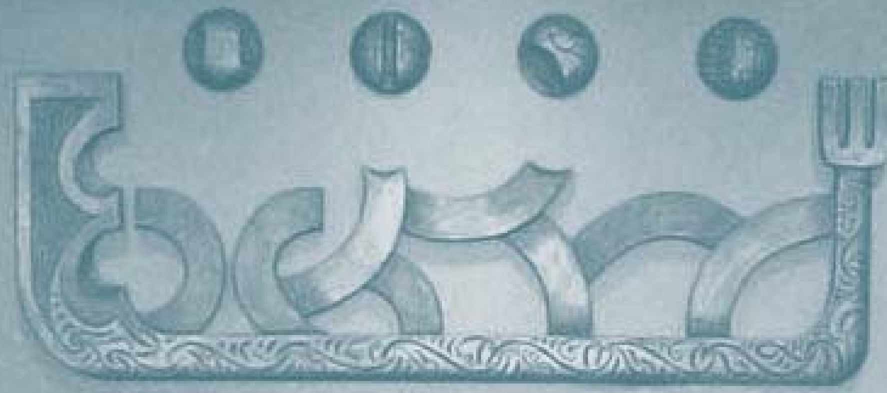


Bulletin from the
Health and Disability Commissioner
and Advocacy Services

No 3, March 2005

HDC Pānui

Awareness of Code rights: how well are we doing?

During November 2004, Phoenix Research surveyed 1500 New Zealanders over 15 years of age to establish New Zealand adults' level of awareness of HDC, the Code, and knowledge and use of complaints services. The survey revealed that 72% of those asked were aware they have rights; 58% were able to name at least one right, and 38% of the population could name two or more rights. Being treated with respect was the right most often named (18% of those who knew they had rights); other rights more commonly recognised were the right to information and the right to professional service and standards of care. Women were significantly more aware of their rights than men. The groups where awareness was lowest included manual workers, labourers, younger age groups and people of Māori and Asian ethnicity.

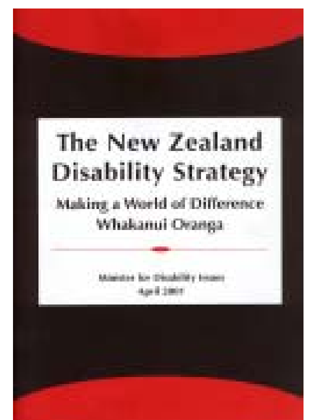
Phoenix suggested that awareness of rights may be linked to frequency of using health services. For example, data from Ministry of Health publications (*A Snapshot of Health 2002/2003*, *1996/7 New Zealand Health Survey*) show that men are significantly less likely than women to visit their GP. Women are also likely to visit their GP more frequently than men and frequency also increases with age. Asian and Māori men are less likely to visit their GP than European/ Pakeha or Pacific men.

In HDC surveys conducted in 1997 and 1998, 29% and 35% respectively were aware of having rights; however, these surveys were conducted amongst service users, rather than the general population. These consumer groups may have had a higher level of awareness than the general population. Therefore a result of 72% for the general population in 2004 indicates a significant increase in awareness over the last six years.

Ordering HDC resources

Leaflets, posters and other HDC educational and promotional resources can now be ordered via the website, without the need for phoning or faxing. Look for the orange button 'HDC shop' on the home page. (www.hdc.org.nz)

Promoting a more inclusive society



HDC is committed to the NZ Disability Strategy, and has its own implementation plan. This can be viewed at the Office for Disability Issues website at http://www.odi.govt.nz/nzds/work-plans/july04-june05.html.

To date we have:

- developed accessibility guidelines for staff using off-site venues
- reviewed recruitment and selection processes within HDC to ensure that people with disabilities are represented on our staff
- provided funding towards the Royal NZ Foundation of the Blind Telephone Information Service, and updated all audio information about HDC and Advocacy
- developed a database of people with disabilities available to be contracted for work with HDC staff nationally
- developed case studies relevant to disabled people for use in presentations and education sessions
- worked with People First to produce a poster illustrating how to sort out a problem with a disability service.

Proposed activities include modification of the website to ensure that it is accessible for people with disabilities, and that disability websites have links to the HDC website.

Case study

Complaints from consumers about the quality of their health care can expose problems in practices or systems and lead to improvements in services.

Mrs A consulted her GP because she had developed a hoarse voice, stridor, a tender gland in the right side of her neck,

right-sided jaw pain, had trouble clearing her throat, and had lost 30kg in weight. She was referred urgently to the Ear, Nose and Throat (ENT) outpatient clinic. It was felt that she had cancer of the epiglottis. She was sent for an urgent CT scan of the chest and abdomen for further assessment.

The radiology registrar, who was in his third year of training, discussed the CT scan with his supervising consultant. The registrar's report recorded fibrotic changes around the descending thoracic aorta and branch of the left main bronchus. He noted that these could be associated with Mrs A's previous radiotherapy for breast cancer, but the possibility of a new malignancy could not be ruled out. He recommended a follow-up scan in three months' time.

Mrs A was subsequently seen regularly at the outpatient clinic by an ENT surgeon, who found that her hoarseness continued despite treatment. Six months after her initial presentation the surgeon referred her for a further CT scan, which showed a 3cm lesion in the left upper zone of the lung with infiltrating mediastinal disease. Mrs A was told that she had adenocarcinoma of the upper lobe of the left lung. When she asked about treatment, her doctor told her it would not do any good at this late stage, but that she could have had treatment earlier when the lesion had first been identified.

Mrs A complained to the Commissioner. She alleged that the radiology registrar and his supervisor had not provided services of an adequate standard in reviewing her CT scan and advising that she required follow-up in three months' time. She maintained that they must have known from the first scan that she had cancer and had not informed her of the diagnosis. She also complained that by the time of the second scan, it was too late for her to have any treatment. She died ten months later.

The Commissioner's expert advisor, Dr David Milne, radiologist, advised that the radiologist's report fell short of an appropriate standard of care because two relevant observations had been missed and one misinterpreted. Therefore their conclusions were weighted towards a benign explanation for the appearances. Dr Milne also raised the issue of who had responsibility for the scan report, noting that as the registrar was not vocationally registered he was under the supervision of a consultant. Dr Milne advised that the consultant was therefore responsible for the quality of the report.

The consultant informed the Commissioner that the observations were not missed, but the observations and findings he discussed with the registrar were not adequately described in the registrar's report. The procedure for CT reporting at that time was for the supervising consultant to review all CT scans with the radiology registrar and discuss the registrar's observations, conclusions and suggestions for further management. Following the consultation, the registrar dictated a report, and edited and signed it. The supervising consultant did not usually review the final report.

The consultant stated: "I was therefore unaware of the language used or the relevant conclusion stated in [Mrs A's] reported CT findings. I relied on [the registrar's] ability to accurately represent the findings that we had discussed during our consultation/discussion … I did not see the final report nor do I agree with the way the findings have been presented. They are not as I would have presented them." Unfortunately, and importantly, the report contained "inconsistencies between what I believe should have been dictated and what was in fact dictated".

The Commissioner's investigation into the complaint revealed that the radiology department's reporting system was flawed. It could allow a report that contained errors by a radiology registrar to be placed in the medical record and released to other treating clinicians, without first being checked by the consultant radiologist.

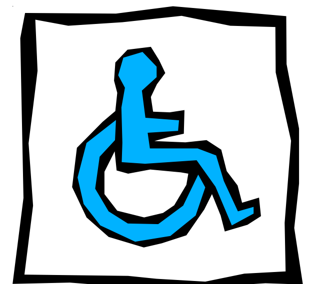
Following the finding of inadequacies in the system, the radiology department reviewed the need for greater oversight of junior medical staff in respect of radiological film examination and reporting. Draft reports by junior medical staff are now reviewed by a consultant radiologist until those responsible for staff training, in consultation with senior medical staff, are satisfied that the individual registrar is competent to report without such supervision.

(www.hdc.org.nz/opinion 03/HDC08493)

Advocacy making a difference

A lady who uses the mobility transport approached us for support following an accident that resulted in her sustaining a broken finger on the only hand she is able to use. The driver of the mobility van had strapped her wheelchair into the van (not very securely), but she was not restrained in any way, so when the driver braked hard she fell out of the wheelchair and the wheelchair fell forward. An advocate assisted her to take the matter to the provider of the service.

Because the complaint involved the mobility taxi, they were obliged to notify LTSA. A representative of LTSA met with the consumer and the advocate, and it turned out that there was no policy regarding restraint of wheelchairs or their occupants. The upshot is that they have invited the advocate to take part in a Regional Council meeting with the Total Mobility Advisory group to look specifically at the development of a policy for the use of lap belts or other devices to ensure the safety of consumers in wheelchairs who use mobility taxis. Once the policy has been developed LTSA will look at implementing it nationally.



We welcome feedback on *HDC Pānui*. Please send any comments about information you would find useful to Elizabeth Finn, Education Manager, at panui@hdc.org.nz. *HDC Pānui* is also available on www.hdc.org.nz.