Recurring Themes

I am pleased to have this opportunity to share some of my thinking after six months as Health and Disability Commissioner. In this note I will consider some recurring themes arising in the cases that have come before my Office.

Our health and disability system works well in the vast majority of the millions of interactions with consumers that occur each year.[1] In this context HDC advocates assist with over 3,500 enquiries, and my Office receives around 1,500 complaints per year. Each represents an opportunity to learn. The human stories that are reflected in the complaints I receive often involve individual tragedies. Resolution for consumers often involves understanding what really happened, combined with the hope that the lessons learnt mean the same thing is less likely to happen to somebody else.

I have been struck by the number of complaints which relate to a failure to get the basics right. I am interested in how well we learn as a system - why errors are repeated and how to reduce repetition. If we are to have a learning system we need to understand the individual and systemic causes of error and their context.

Thus I am interested in the themes that recur in the cases before this office. In cases concerning anaesthetists the theme that seems to occur most frequently – and in fact it is difficult to find cases past or present that deal with anything else – is that of informed consent.

Much has been written of informed consent by my predecessors over the years in articles and cases, and the cases before me indicate the issue retains its currency.

I am conscious in this context that doctors are communicating complex and important information to patients at a time when patients are under some stress. It is important, circumstances permitting, that the conversation takes place at a time and in a way that allows a patient to process that information, and make an informed decision, which should be recorded.

The three cases below demonstrate some issues that recur in the system.

Case – Failure to provide information and obtain informed consent (05HDC07699)

A 76-year-old woman had knee replacement surgery at a public hospital. In a pre-operative assessment she told the duty anaesthetist she could not have morphine because of an allergy. The doctor recorded the allergies in the notes and said that before surgery other options would be discussed with her by the operating anaesthetist.

On the day of surgery the patient and the anaesthetist, meeting for the first time, discussed the patient's concerns. This took place outside the theatre suite. The woman suffered adverse effects post-operatively and was admitted to ICU.

[1] For example, acute hospital discharges exceed 660,000 per annum; primary care interactions exceed 18 million consultations per annum. Source: Ministry of Health.

It was decided that it was not appropriate for such a detailed and important conversation to take place when the patient was in a vulnerable position immediately prior to surgery. It was also decided that the anaesthetist failed to provide the patient with sufficient information about her condition, alternative anaesthetic options, and her right to refuse treatment. This meant the patient could not give informed consent. The doctor also failed to record the information he gave the patient, or whether she had consented to the use of morphine.

Communication of risk is another recurring theme. The following two cases demonstrate aspects of the communication of risk that will be of interest, although in neither case did the complaint specifically involve the anaesthetist.

Case – risks of medical device failure (09HDC00795)

A 56-year-old man was diagnosed with advanced colon cancer with secondary cancer of the liver. After surgery to remove cancerous tumours in his bowel, he was referred to a gastroenterology and hepatobiliary surgeon in his private practice for assessment and ongoing treatment.

The surgeon discussed the treatment options and provided an information booklet about liver cancer diagnosis and treatment. The treatment was costly and only available through the private sector. As the patient did not have medical insurance the costs were specifically discussed. The patient opted to have the treatment and initially responded well. At subsequent assessments it was found the cancer was progressing and so the surgeon recommended further treatment at the cost of between $18,000 to $20,000. This did not include covering the costs of removing the surgically placed vascular access device if it was found the device was not functioning.

In the event the device was ineffective and the patient had to make a decision at short notice to undergo further surgery at an additional cost of $7,000.

It was decided that although the standard of care was appropriate the surgeon breached Right 6(1)(b) because of the failure to discuss the specific risk of device failure and the additional costs at the time the repeat oncological treatment was discussed. It was considered that this was information that a reasonable patient in these circumstances would expect to receive.

Case – outcome risk (09HDC01870)

The patient, who was aged 64, had colorectal cancer with liver metastases and chemotherapy was no longer effective. He underwent an anterior resection of the rectum, a cholecystectomy and an insertion of a hepatic artery port-a-cath. He made a slow recovery and it was discovered that he had developed an anastomotic leak or other viscus perforation within his abdomen.

The case revolved around the extent to which the risk of an anastomotic leak had been explained to the patient and whether he had been given the opportunity to choose to have a defunctioning ileostomy.

The surgeon had advised the patient that the risk of an anastomotic leak was 5%. Expert advice was that the risk was much higher (20-25%). The surgeon argued that it was not possible to precisely attribute a risk to an individual patient and that is not what the patient seeks or can expect. The Code provides that "patients are entitled to the information that a reasonable patient, in their circumstances, would expect to receive" including "an explanation of the options available including an assessment of the expected risks, side effects, benefits, and costs of each option"[2]. The decision stated that a patient in this patient's circumstances would certainly expect to be told about risks that the surgery itself might worsen his overall condition. The former Commissioner stated that he agreed with the provider's point that patients do not expect mathematical precision. However there is a major difference between a 1 in 20 (5%) risk and a 1 in 5 (20%) risk.

The surgeon argued that even if he had told the patient of a 20% risk the patient would still have opted for surgery. However, it is no answer to a failure to provide adequate information to claim the patient would have opted for surgery no matter how high the risk. The patient is still entitled to the information before making a decision. As stated in that opinion, "patients in desperate circumstances who are being encouraged to undergo innovative procedures, are particularly in need of full information that does not downplay any risks they face. The 'more advanced and rare' the surgery … the greater the need to err on the high side when describing well recognised risks."

Conclusion

We have a strong system here in New Zealand that works well the great majority of the time. The complaints providers receive can provide a valuable opportunity to learn, and to strengthen that system. We all benefit when safety and quality are improved.

Christchurch earthquake

As I conclude this article we are two days on from the devastation of the Christchurch earthquake. Stories of the incredible response of so many people are beginning to be heard outside of the city. Stories of people going to extraordinary lengths, sometimes at great personal risk, to help others. I want to acknowledge the courage and the care, and the extraordinary work, in medical facilities and in the field, in such terrible circumstances. It is the overwhelming humanity of the health sector that is its strength, and we are seeing that revealed again and again. Some of you who read this will be directly involved, and all of us are touched in some way. The thoughts and prayers of all of us at the HDC are with you.

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[2] Right 6(1)(b) of the Code of Health and Disability Services Consumers' Rights