HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failure to administer local anaesthetic breaches the Code
20HDC01208

In a report issued today, the Health and Disability Commissioner Morag McDowell found a gynaecologist and an obstetrics and gynaecology trainee breached the Code of Health and Disability Services Consumers' Rights (the Code).

The breach concerns the care provided to a woman in her twenties who underwent a procedure at Greenlane Hospital to remove abnormal cells from her cervix following results from a smear test.

The LLETZ procedure employed to remove the abnormal cells was commenced without administering local anaesthetic, causing the woman significant pain.

Ms McDowell found the gynaecologist (in the role of supervisor and most senior doctor involved in the procedure) and the obstetrics and gynaecology trainee/ registrar who performed the procedure breached the Code for failing to provide services with reasonable care and skill | Tautikanga.

"The standard of care applicable is the care and skill that an ordinarily careful peer of the clinicians involved would exercise under similar circumstances," said Ms McDowell.

"Most clinicians would have ensured that local anaesthetic was applied prior to commencing the LLETZ procedure."

Ms McDowell was satisfied that the issues outlined in the case were primarily the responsibility of the individual clinicians involved. However, she was critical that Health New Zealand | Te Whatu Ora Te Toka Tumai Auckland failed to upload the woman's consent form to her file. She also said a more empathetic approach was warranted by Health New Zealand after this adverse event, including personal contact to assist in the woman's recovery.

Ms McDowell was unable to make a finding regarding the differing recollections around whether the registrar and gynaecologist had notified the woman of their respective roles as trainee and supervisor when seeking consent for the procedure.

However, she took the opportunity to remind both doctors and Health New Zealand of the need, when undertaking procedures, to clearly identify clinicians and their roles to the patient, and to ensure that consent is obtained in circumstances where teaching is taking place.

Since the event Health New Zealand, the gynaecologist and registrar have made changes to their practice. In addition, Ms McDowell outlined further recommendations in her report, including for the gynaecologist and the registrar to provide formal written apologies to the woman.

Ms McDowell also recommended that Health New Zealand consider implementing as a requirement the practice of using saline wash at the end of all gynaecological procedures that use iodine and consider updating its adverse event policy to require a follow-up to patients who have suffered an adverse event.

27 May 2024

Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's 'Latest Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

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