HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Multiple rights breached in use of surgical mesh
22HDC00810

The Deputy Health and Disability Commissioner has found that an obstetrician and gynaecologist breached Right 6(1) of the Code of Health and Disability Services Consumers' Rights because a continence procedure (a suburethral sling made of mesh material) was not discussed with the patient, or documented in detail, prior to being performed. The woman at the centre of the complaint had given specific instructions that mesh was not to be used in the procedure.

Rose Wall said that without this information, the woman was not able to make an informed choice and give informed consent to the surgery and consequently found the obstetrician and gynaecologist had also breached Right 7(1).

Ms Wall determined that because the suburethral sling had been placed incorrectly, the obstetrician and gynaecologist had failed to provide services with reasonable care and skill, in breach of Right 4(1). The obstetrician and gynaecologist was also found to have breached Right 4(2) for documentation that was not up to the standard required by the Medical Council of New Zealand.

He told HDC that, at a consultation, he advised the woman of the procedure he intended to perform which included a suburethral sling (comprised of surgical mesh and generally used for stress or urge incontinence) verbally, using an anatomical model to demonstrate, supported by a brochure.

The woman said she did not receive the brochure, nor any other notes, and that she explicitly stated that she did not want surgical mesh used. She also said the only information she was given about the procedure, was a hand drawn explanation.

Rose Wall said there is no record of what was discussed in relation to surgical mesh, its use, or of any risks associated with it. She also noted that there was no record of discussions about alternative treatment options or that there was clinical evidence that the woman was experiencing stress or urge incontinence.

The woman discovered surgical mesh had been used when she accessed her clinical records three years later. Notes following surgery to remove the mesh stated that it was found in a very unusual location.

Rose Wall acknowledged that the woman had experienced life-changing complications, including ongoing chronic pain and other issues. "Understandably these events have had a profound impact on Ms F's quality of life," she said.

Outlining her reasons for the breaches she said, “A reasonable consumer in Mrs F’s circumstances would expect to be informed of a procedure (suburethral sling) that was to be performed to prevent stress urinary incontinence, and the known risks of the procedure including chronic pelvic pain, recurrent incontinence, and mesh erosion and any such discussions, should have been reflected in the documentation.”

She was also critical that the reason for the suburethral sling was not discussed in detail “particularly because the referral stated that Mrs F’s prolapse was not associated with any stress or urge incontinence.” She went on to add that the doctor had not provided services with reasonable care and skill in incorrectly placing the urethral sling, and that his documentation was not up to the standard required by the Medical Council of New Zealand.

Since the events the doctor has apologised to the woman. He has advised HDC that he now contacts patients prior to their surgery to double check that there are no unanswered questions.

Noting systemic measures already taken to reduce the risk of harm from surgical mesh, Rose Wall recommended the doctor undertake further training on the informed consent process, documentation and the Code.

Background - HDC and surgical mesh

HDC – alongside Te Tāhu Hauora| Health Quality & Safety Commission and other agencies – sits on the Surgical Mesh Round Table which oversees and monitors a surgical mesh work programme led by Mānatu Hauora| Ministry of Health. This programme includes actions and recommendations from the Health Committee and Restorative Justice Reports.

The Director General of Health supported a pause on the use of surgical mesh for stress urinary incontinence in August 2023 until four conditions are met:

- Mandatory credentialling of clinicians to the National Credentialling Framework for Pelvic floor reconstructive, urogynaecological and mesh revision and removal procedures
- The establishment of a mesh registry for female pelvic floor procedures including surgical mesh
- A structured informed consent process
- Patient case discussion at multidisciplinary meetings.

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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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For more information contact:

Communications team, Health and Disability Commissioner

Email: communications@hdc.org.nz, Mobile: +64 (0)27 432 6709