



## **Effective communication and adequate consent prior to surgery 20HDC01873**

The Health and Disability Commissioner has found an obstetrics and gynaecology consultant at Te Whatu Ora (Te Pae Hauora o Ruahine o Tararua Mid Central), breached the Code of Health and Disability Services Consumer's Rights (the Code) for an inadequate informed consent process prior to a patient's surgery.

In a pre-admission appointment the female patient in her fifties had agreed to the surgical removal of her uterus and fallopian tubes using a bikini incision, and that her ovaries would be retained. However, just prior to surgery the patient was informed of the clinical recommendation to use a midline incision and also to remove both ovaries. A consent form was signed on this basis.

Morag McDowell found the clinician responsible for the patient's care breached Right 5(2) of the Code which gives consumers the right to effective communication through an environment that supports open, honest and effective dialogue.

The clinician also breached Right 7(1) of the Code which ensures a person's right to make an informed choice and give informed consent.

"It was not appropriate to introduce such changes to the woman's surgery so late in the process when there was insufficient time for her to make a considered decision to proceed with the surgery," Ms McDowell said.

"The informed consent process should have taken place in an environment that enabled the woman to communicate openly, honestly and effectively with her healthcare providers," said Ms McDowell. "The patient did not have the opportunity to give unpressured consent".

Gaps in the system at Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral (formerly MidCentral District Health Board MCDHB) contributed to the breaches in care, Ms McDowell noted. Staff did not call the consultant (as he had requested) for the patient's pre-admission appointment (where he expected to undertake the consent discussion), and clinical records from that appointment were not signed. This resulted in an inability to identify the clinician who had seen the woman prior to surgery.

Since the incident the consultant has conducted an audit of the consent process and consent form and presented this to Te Whatu Ora. He no longer sees patients in the pre-admission clinic but has allocated a time slot in his gynaecology clinic to see preoperative patients. He has also advised his medical lead that if a patient is not booked in to see him at pre-admission, he will not operate.

Te Whatu Ora has also made changes, including initiating a review of the theatre bookings and pre-admission processes to ensure a safe pathway for patients and staff through the gynaecology outpatient clinic, theatre booking process, pre-admission clinic and operating theatre.

Ms McDowell recommended that the clinician provide a written apology to the patient for his breaches of the Code.

She also made a number of recommendations for Te Whatu Ora, including that it:

- Apologise to the woman for the system issues identified.
- Provide an update on its review of theatre bookings and pre-admission processes.
- Share this case anonymously with relevant surgical staff for educational purposes.

**27 March 2023**

***Editor's notes***

The full report of this case will be available on HDC's [website](#). 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).