Southern District Health Board
(now Health New Zealand|Te Whatu Ora Southern)
Consultant Neurosurgeon, Dr B

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC01118)

HDC
Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary 1
Complaint and investigation 2
Information gathered during investigation 3
Opinion: Health NZ Southern (previously Southern District Health Board) — breach 17
Opinion: Dr B — adverse comment 22
Changes made 26
Recommendations..27
Follow-up actions 27
Appendix A: Independent clinical advice to Commissioner 28
Appendix B: Health NZ Southern informed consent policy 31

Executive summary

1. This report concerns the care provided to a woman who presented to Health New Zealand|Te Whatu Ora (Health NZ) Southern's Neurosurgery Department with neurological symptoms, and the two spinal surgeries she underwent subsequently. The case involves several issues, including the adequacy of communication, the clinical documentation throughout the patient journey, and the management of the woman's complaint made directly to the provider.

2. Prior to the initial surgery, the operating surgeon was changed. The surgeon stated that he met with and discussed the proposed approach with the woman, but she has no recollection of being informed of the change. After the initial surgery, the woman did not improve and her symptoms deteriorated, so further surgery was arranged. Following the second surgery, the woman was prescribed and administered dexamethasone, although the woman said that this was never discussed with her. After the events, the woman made a complaint directly to the hospital, but she experienced delays in contact to update her on progress of the internal investigation.

3. This case highlights the importance of the consumer's right to informed consent, and for this to be facilitated in an environment that allows for open and effective communication.

Findings

4. The Deputy Commissioner made adverse comment about the adequacy of the surgeon's discussion with the consumer about the change in surgeon prior to the surgery.

5. No discussion was documented regarding the prescribing of dexamethasone. The Deputy Commissioner considered that this reflected the pressured environment in the service. As Health NZ Southern had overall responsibility for the service provided, it was found in breach of Right 6(2) of the Code for this aspect of the woman's care. The Deputy Commissioner found that the woman did not give her informed consent to the administration of dexamethasone, and therefore that Health NZ Southern also breached Right 7(1) of the Code.

6. Documentation in the Neurosurgery Department was found to be well below the expected standard and in some areas non-existent. Accordingly, the Deputy Commissioner found that Health NZ Southern breached Right 4(2) of the Code.

7. The Deputy Commissioner criticised Health NZ Southern's delays in contact with the woman to provide updates on the progress of its internal investigation.

Recommendations

8. The Deputy Commissioner recommended that the surgeon undertake HDC's e-learning module on informed consent processes. A further recommendation to review his complication rates for decompression surgery against those of his peers was completed in response to HDC's provisional report.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

9. The Deputy Commissioner recommended that Health NZ Southern provide a letter of apology to the consumer; review its training for neurosurgery service staff regarding the informed consent policy; audit the standard of record-keeping in the neurosurgery service; and report to HDC on progress with securing an IT system to support the surgical booking, documentation, and quality processes and the introduction of scOPe.

Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from Ms A about the services provided by Southern District Health Board[1] (now Health New Zealand|Te Whatu Ora (Health NZ) Southern. The following issues were identified for investigation:

- *Whether Southern District Health Board provided Ms A with the appropriate standard of care in 2019 and 2020.*
- *Whether Dr B provided Ms A with an appropriate standard of care in 2019.*

11. This report is the opinion of Deputy Health and Disability Commissioner Dr Vanessa Caldwell and is made in accordance with the power delegated to her by the Commissioner.

12. The parties directly involved in the investigation were:

Ms A	Consumer
Southern District Health Board	Provider
Dr B	Provider/consultant neurosurgeon

13. Further information was received from:

Dr C	Provider/consultant neurosurgeon
Dr D	Provider/neurosurgery fellow
Dr E	Provider/registrar
Dr F	Provider/general practitioner (GP)
Dr G	Provider/neurologist
Dr H	Neurosurgeon, ACC expert

14. Independent advice was obtained from a neurosurgeon, Dr Agadha Wickremesekera (Appendix A).

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Health New Zealand|Te Whatu Ora. All references in this report to Southern District Health Board now refer to Health New Zealand|Te Whatu Ora Southern.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information gathered during investigation

Introduction

15. This report concerns the care provided to Ms A by Health NZ Southern, in particular the care provided by the neurosurgical service when Ms A presented with neurological symptoms related to a spinal disc protrusion (a back injury) in 2019.

16. The report examines the adequacy of communication and consent obtained prior to Ms A's two spinal surgeries, the standard of care and treatment provided during her admission, and Health NZ Southern's response to her complaint over 2019 and 2020.

Background

17. Ms A is a medical practitioner.

18. In late 2018, Ms A noticed that she had mild bilateral numbness in her fingertips, which was noticeable when she was washing her hair. She said that at that stage, the symptom was stable and was not affecting her work, and it was not causing her any discomfort or pain.

19. During the period 26–28 December 2018, Ms A was working in her garden, including moving a heavy item, which involved using significant upper body force.

20. On the evening of 28 December 2018, Ms A had a 'tight' neck, and shoulder pain. On 29 December 2018, Ms A was extremely fatigued and slept for several hours during the afternoon, and the next day whilst at work, she noted difficulty with typing.

GP consultation 7 January 2019

21. Ms A told HDC that she saw Dr F at the medical centre on 7 January 2019 because the numbness was starting to travel up both her arms toward her elbows, although she had no pain or discomfort. She said she did not have any lower limb, bowel, or bladder dysfunction at that stage.

22. Dr F requested blood tests and sent an urgent referral to the Neurology Department at the public hospital. The referral states that Ms A's symptoms had progressed markedly over the previous two weeks, but it does not mention the events around the moving of the heavy item.

Neurology consultation 14 January 2019

23. On 14 January 2019, Ms A saw consultant neurologist Dr G at the public hospital. Ms A recalled that she told him that the numbness had progressed rapidly over the previous two weeks, and she also mentioned to him that she was having urinary hesitancy and the feeling of incomplete emptying, and she had noted a change in her bowel habits.

24. Dr G recorded that Ms A mentioned having recently been constipated, but he made no record of her mentioning issues with her bladder.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

25. In a clinic letter dated 16 January 2019, Dr G outlined that he thought Ms A's presenting features suggested a cervical cord (spinal cord) lesion. The reporting letter does not mention the garden incident, but it notes that Ms A was happy to pay for a private scan.

26. Dr G told HDC that he is confident that Ms A did not mention any injury to him.

MRI 21 January 2019

27. On 21 January 2019, Ms A had a privately funded MRI[2] scan, which showed a back injury — a disc protrusion near the middle of the neck[3] causing significant narrowing of the spaces within the spinal canal,[4] as well as mild spinal narrowing at the base of the neck.[5] Spinal narrowing can put pressure on the spinal cord and nerves.

28. On the same day, following receipt of the results, Dr G referred Ms A to the neurosurgical team at the public hospital for 'urgent management', and asked that a CT scan[6] be performed.

CT scan 29 January 2019

29. Ms A said that she contacted the Radiology Department on 24 January 2019 because she had not heard from it regarding a date for her CT scan, and she was very concerned about her progressive numbness and lower limb/bowel/bladder symptoms.

30. Ms A said she was told that the CT scan had been triaged as urgent (within one week), but the current wait time was six weeks. She then emailed Dr G, as she was very concerned about the delay.

31. Dr G expedited an imaging appointment for 29 January 2019, and Ms A had a CT scan that day.

Preadmission clinic 29 January 2019

32. Following the CT scan, Ms A received a call from neurosurgical registrar Dr E, who told her to come to the pre-admission clinic that afternoon as she was to undergo spinal surgery — an anterior cervical discectomy and fusion (ACDF)[7] — the following day.

33. Ms A was seen by surgical fellow Dr D and Dr E at 12.45pm.

---

[2] Magnetic resonance imaging (MRI) is a non-invasive technique used to create detailed three-dimensional pictures of parts of the body.
[3] Ms A had a broad-based disc protrusion at the C3–C4 level of the cervical spine.
[4] Spinal stenosis.
[5] C4–C7 level of the cervical spine.
[6] A computerised tomography (CT) scan combines a series of X-ray images taken from different angles around the body and uses computer processing to create cross-sectional images of the bones, blood vessels, and soft tissues inside the body.
[7] Surgery to remove a herniated or degenerative disc in the neck. An incision is made in the throat area to reach and remove the disc. A graft is inserted to fuse together the bones above and below the disc.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Assessment

34. Health NZ Southern stated that there is no comprehensive neurological examination recorded in the notes, but only an abbreviated clinical assessment. Dr D said that he went through Ms A's history and conducted a full examination, while Dr E documented the notes.

35. The notes state that Ms A had had symptoms for three months and had reported urinary hesitancy 'in recent months'. Ms A told HDC that this is incorrect and, other than the fingertip numbness she had noted when washing her hair and an isolated incident of fumbling with a water bottle cap, she had no other symptoms until she noticed a dramatic change on 30 December 2018. She said that she did not have any lower limb, bowel, or bladder symptoms when she first visited her GP on 7 January 2019, and she reported those symptoms only when she saw Dr G on 14 January 2019.

36. Dr E also recorded that Ms A had impaired heel–toe walking.

Discussions of garden incident and options

37. Ms A said that she told Dr D and Dr E about the garden incident, but none of the information she provided was documented in her notes.

38. However, Dr D stated: 'At no point of time during the clinical pre-assessment did [Ms A] mention about [the garden] incident.'

39. Dr E said that he remembers only some aspects of Ms A's case and does not remember whether she mentioned the garden incident. The incident is not recorded in the notes.

40. Dr D stated that he discussed the options of conservative versus surgical management and informed Ms A of the complications that might occur during the surgery. He said that Ms A asked him about his qualifications, and he told her that he was a fellow (a trainee) not a consultant, and that Dr C was the consultant who would be operating on her.

41. Ms A did not wish to sign the consent form as she wanted to speak to Dr C directly. Dr D contacted Dr C, who said that he would come when possible.

Further discussion with Dr C and consent process

42. Dr C said that he and Dr E saw Ms A later that afternoon and explained the details of the planned surgery and the possible complications, including unsuccessful or insufficient decompression,[8] as well as persistence or increase of neurological deficits, and he answered Ms A's questions.

43. Dr E completed the consent form on delegation from Dr C and noted on the consent form the areas discussed during the consent process. Ms A consented to the procedure.

44. There is no preoperative documentation, and there are no dictated clinic letters written by the neurosurgeons.

[8] Decompression refers to treatment of compressed nerves in the spine.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

45. In relation to the lack of clinic letters, Dr C explained that Ms A was seen acutely and not in the neurosurgical clinic, and the only preoperative notes made in neurosurgery originated from the admission and were written by a registrar. He noted that this kind of management was typical and did not appear unusual to him.

Surgery delayed — 30 January to 4 February 2019

46. Ms A said that when she returned on 30 January 2019 for admission, she was told that she was now third on the operating list (at preadmission clinic she had been told that she would be first on the list, to arrive by 6am, and to fast until the surgery). At 2.30pm Dr E and Dr C told her that the first two surgeries had run over time, and she would be placed on the acute theatre list. She was admitted and told that she could go on overnight leave, and that she was to return fasted at 7am the following day.

47. Ms A said that she returned on 31 January 2019 as directed and waited until mid-afternoon, at which point she was again told that she could go on leave, and she was to return fasted the following morning.

48. Ms A said that the house officer contacted her on Friday 1 February 2019 in the late afternoon (she had remained fasted at home) and told her that there would be no surgery over the weekend, but she was first on the list on Monday 4 February 2019. She was told to come to the public hospital at 8pm on Sunday 3 February 2019.

49. Ms A said that when she presented as instructed, the nursing staff said that she had been a 'no show' the previous day and there was no longer a bed for her. After approximately one hour this was sorted out, and she was given a bed. Ms A said: 'I find it inconceivable that a patient on the acute theatre list, in the community, with cord compression is marked as a "no show", with no attempt to contact them.'

First surgery — 4 February 2019

50. The ACDF surgery was undertaken on 4 February 2019, performed by consultant neurosurgeon Dr B, not Dr C.

Change of surgeon

51. Dr C said that as Ms A's surgery had to be postponed because of restricted theatre capacity, she was placed on Dr B's theatre list.

52. There is no record of the information that was handed over by Dr C to Dr B. Dr C stated that this reflected the situation in the department at the time, and due to different schedules, he and Dr B did not see each other often and he could obtain a picture of the treatment strategy only from the clinical notes of the registrars. However, Dr C told HDC that he informed Dr B about the care and the current management plan.

53. Dr B said that he requested that Ms A be moved from first to fourth on the list so that he could meet her prior to the surgery. Dr D and Dr B said that they were both present when Dr B discussed with Ms A the approach that would be taken during the surgery. There is no record of this meeting.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

54. The operation note records that Ms A was 'marked using anatomical landmarks', which infers that there was some contact with a member of the neurosurgical team on the day of surgery prior to the operation.

55. In her response to my provisional decision, Ms A stated that she was not moved to fourth on the theatre list on the day of her surgery. She was taken to theatre after 7am and her surgery started at around 8.15am. This is supported by the anaesthetic record, which shows recordings taken while under anaesthetic from approximately 8.15am onwards.

56. Dr B told HDC that no dictation was done by him as Ms A had been seen by the senior medical officer (SMO) and the clinical fellow (Dr C and Dr D), and they are 'the same team'.

57. Ms A said that when she awoke in recovery, to her surprise, Dr B explained that he had done the operation. She said that she had not been informed that the surgeon who had consented her (Dr C) would not be performing the operation, and she was not kept awake prior to the arrival of Dr B to be introduced to him.

58. Health NZ Southern said in its Clinical Incident Report[9] that the reason why Ms A did not recall the conversation with Dr B may have been either due to the effects of the premedication she had received or the busy operating theatre environment. The Clinical Incident Report also stated that 'this discussion was too late and not in line with Health New Zealand|Te Whatu Ora Southern policy'.

59. The clinical record shows that anaesthetic consent was signed on the day of the operation, and therefore a discussion with the anaesthetist would have occurred between 7am and 8.15am. The surgical safety checklist[10] 'sign in' process would also be carried out at this time, as the consumer is required to answer questions.

60. In his response to my provisional decision, Dr B denied that he would have spoken to Ms A while she was under the influence of premedication. He stated that this is not his usual practice, and it was suggested by Health NZ as one possible explanation for Ms A's lack of recollection.

61. Further information gathered from Health NZ Southern confirmed that there is no record of any premedication having been given to Ms A prior to her surgery, and therefore premedication would not have been a contributing factor to Ms A's lack of recollection.

62. Ms A told HDC that when Dr B saw her after the surgery, he explained that he could tell that the spinal cord had not been decompressed by the surgery but, as they had never met

[9] Southern District Health Board conducted an internal review of the care that was provided to Ms A, details of which are outlined further below.

[10] To improve surgical safety worldwide, the World Health Organization (WHO) has released a safety checklist for surgical teams to use in operating rooms. The checklist identifies three phases of an operation, each corresponding to a specific period in the normal flow of work. In each phase, the checklist helps teams confirm that the critical safety steps are completed before it proceeds with the operation. 'Sign in' is the first phase and is carried out by the anaesthetist.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

previously and she had not been consented for any other procedure, only the ACDF was done. The handwritten operation note (outlined further below) does not refer to this.

Operation note

63. Ms A's records contain a handwritten operation note, but no typed record of the surgery. Dr E (who is documented as assisting with the surgery) told HDC that there would not have been a typed note to accompany the handwritten operation note as it was not the practice in the department for the surgical team to have formal notes typed to accompany handwritten operative notes.

64. Dr E noted that doing handwritten operation notes, and not doing dictated operation notes that end up on the electronic system, was the standard practice across all surgical services at the public hospital at that time.

65. Health NZ Southern said that the operation note written by Dr E was reviewed by Dr B. The operation note states that an osteophyte (bone spur) was removed. Health NZ Southern said that the presence of an osteophyte or other cause of cord compression such as disc protrusion cannot of itself prove trauma as a causative factor of Ms A's symptoms.

Postoperative care and discussion of further surgery — 4 to 13 February 2019

66. Ms A told HDC that following the surgery, she was generally unwell and felt uncomfortable. She had ongoing urinary retention, and an indwelling urinary catheter was inserted the same day.

67. Ms A was concerned that a catheter had not been inserted prior to the surgery, as she had informed staff that she needed to pass urine and was told that a catheter would be inserted. Dr B told HDC that a catheter is not used routinely during such procedures because of the risk of infection, especially if implants are used. He said that this is discussed 'with the team' at the start of each procedure, but occasionally a catheter will be inserted after the procedure if necessary.

68. On 5 February 2019, a CT scan was requested because Ms A was not improving and had deteriorated after the surgery. The CT scan was performed on 6 February 2019. It found[11] that the very dense soft tissue that could be seen in the area between the membrane and spine at the middle of the neck was likely residual disc material. However, it was noted that because of the limitations of the CT scan, it was possible that this was bleeding occurring between the outer covering of the brain and the skull.

69. On 7 February 2019, Ms A underwent an MRI scan, which indicated that there was ongoing spinal narrowing at the middle of the neck, causing spinal cord compression.[12] The scan

[11] The CT scan found hyper-dense soft tissue in the C3/C4 anterior epidural space, which 'likely represent[ed] residual disc material, however, allowing for the limitation of CT, an epidural haematoma cannot be excluded'.
[12] The scan report stated: 'Ongoing focal spinal stenosis at C3–4 level causing cord compression. Appearances of the spinal canal and spinal cord at this level are similar to the preoperative MRI dated 21/01/2019.'

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

report noted that the spinal canal and cord in that area appeared similar to the MRI scan taken prior to the surgery.

Dr B's response about outcome of first surgery

70. Dr B told HDC that the residual disc material after the first ACDF was not large, so revision of the ACDF was not the best option for Ms A. He said that Ms A was given time to improve after the first operation and, when her progress was static, she was offered further decompression (treatment of the compressed nerves) posteriorly, after discussion.

71. Dr B said that it was well known to spinal surgeons that operating on patients with myelopathy (compression of the spinal cord) would be to stop progression, but with no guarantee of improvement.

Discussion of further surgery and consent process

72. On 8 February 2019, Ms A met with Dr B and they reviewed the imaging. She said that they discussed the ACDF and Dr B told her that the findings were consistent with a recent traumatic herniation[13] as the disc was soft. They discussed further spinal surgery — a posterior laminectomy[14] — for definitive decompression and debated either delaying the surgery for six weeks to allow the fusion to settle or proceeding more quickly. Dr B said that they would leave the urinary catheter in situ for the next four to six weeks.

73. Ms A considered the options over the weekend and then asked to discuss them further with Dr B, as she was concerned that any delay might cause further sensory loss. Dr B came to see her on 12 February 2019, and it was decided to proceed with further surgery, but she was told that this would not be performed until later that week or the following week.

Consent form for second surgery

74. On 12 February 2019, Dr E approached Ms A with a consent form and told her that she was booked first on the list for the following day. Ms A said that she asked what levels of the spine the surgery would be performed on, and Dr E told her that he was unsure as Dr B and Dr C had different opinions.

75. Ms A said that she would not sign the consent form until she had discussed with the surgeon who would be performing the operation and exactly what was going to be done.

76. Later that day, Dr C discussed the planned surgery with Ms A. Dr C said that the surgery was scheduled for 13 February 2019 and, as Dr B would not be present that day, he had asked Dr C to undertake the procedure.

77. Dr C cannot recall the exact reason for Dr B's absence. Dr C told HDC:

---

[13] A herniated disk refers to a problem with one of the disks that sit between the bones (vertebrae) that make up the spine. A spinal disk has a soft, jellylike centre (nucleus) encased in a tougher, rubbery exterior (annulus). A herniated disk occurs when some of the nucleus pushes out through a tear in the annulus.

[14] A laminectomy is surgery to remove part or all of the vertebral bone (lamina). This helps to ease pressure on the spinal cord or the nerve roots.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

> 'Even though I was not present during the informed consent meeting with [Dr B] [see paragraphs 72–73], I spoke with [Ms A] in the late afternoon before the surgery about the planned procedure, as documented in clinical notes.'

78. Ms A said that she was happy with the planned approach and Dr C's explanation, and she signed the consent form.

Neurological examinations during postoperative care

79. Ms A said that after the surgery, although she was having routine 'neurological observations' involving squeezing her fingers and pushing up and down with her feet (and sometimes pupil constriction), at no point did she have a thorough neurological examination. She said that she was still in urinary retention and had not passed a bowel motion of any substance (other than a small amount post enema).

80. Health NZ Southern told HDC that Ms A was seen regularly and examined by the medical staff post-surgery, and although there is no documentation of any 'comprehensive neurological examination', there are records of 'clinical examination' and of observations by medical, nursing, and physiotherapy staff.

Documentation and escalation to consultants in postoperative period

81. There is limited documentation in the clinical records of discussions of Ms A's postoperative care with the consultant neurosurgeons.

82. In relation to this, Dr E said that while he could imagine that there may have been poor documentation of any consultation, registrars in the department generally speak to the consultants very frequently about postoperative patients under their care.

83. Dr E stated:

> 'The degree of liaison between the team of junior doctors and the consultants was not an issue when I worked in the department. I regret it if we did not comprehensively document what discussions we might have had with the consultants.'

Second surgery — posterior laminectomy — 13 February 2019

84. On 13 February 2019, Ms A underwent her second spinal surgery[15] performed by Dr C. Again, there is a handwritten operation note in the records. Dr C stated that this was the way operation notes were documented whilst he worked in the public hospital. He said that usually operation notes were completed by the assisting registrar and cross-checked by the surgeon, and the lack of documentation reflects the situation in the department at the time.

85. Dr C said that after the surgery, he and Dr E visited Ms A in the recovery room and performed a postoperative examination. Ms A was showing no new neurological deficits, so she was transferred to the ward and given antibiotics.

---

[15] A C3, C4, C5 (levels of the cervical spine) posterior laminectomy with under cutting to C2 and C6.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

86. Ms A said that she had no post-surgical review with Dr C, as he left immediately to travel overseas. She stated that from that point on she was in a lot more pain, and after the patient-controlled analgesia pump was removed, she was given only regular paracetamol and ibuprofen, which was insufficient to control her pain, particularly at night.

Dexamethasone

87. On 13 February 2019, Dr E prescribed dexamethasone[16] 2mg, twice a day for three days. Ms A said that the administration of steroids was never discussed with her. The clinical notes do not record a discussion with Ms A about dexamethasone.

88. Health NZ Southern said that dexamethasone is used routinely in most surgery of the spine and brain to reduce inflammation and if there is any suspicion of swelling. Health NZ stated that sometimes dexamethasone is used on induction or intraoperatively, and it may be continued or commenced postoperatively.

89. Dr E stated that he can no longer recall the details of the case and the clinical indication for prescribing dexamethasone, but generally whenever he prescribed dexamethasone while working in neurosurgery at the public hospital, it was upon receiving instructions from the responsible consultant. He cannot recall whether this was discussed with Ms A and said that it is possible that they did not discuss this with her adequately. He said that he regrets that the instruction from the consultant and any discussion had was not documented.

90. Dr E told HDC that the very heavy workload in the department may have contributed to the lack of documentation of Ms A's care.

Transfer to spinal unit

91. On 20 February 2019, Ms A was transferred to a spinal unit where she was treated with long-acting pain medications and a reflex bowel regimen was commenced.

92. Ms A said that the medical team at the spinal unit had difficulty knowing exactly what the surgical procedure at the public hospital had entailed, so an MRI was done on 1 March 2019 to ascertain the details of the surgical procedure. The MRI showed a fluid collection over the surgical site — likely to be a seroma.[17]

93. Ms A was discharged from the spinal unit on 20 March 2019.

Subsequent events

Outpatient appointment

94. Ms A had a neurosurgical out-patient appointment on 15 April 2019. She said that she asked whether the appointment was with a registrar or with a consultant, as she felt that she had consultant-level questions and she had not had a chance to discuss her surgery with Dr C.

[16] Dexamethasone is a corticosteroid. It relieves inflammation but has several side effects, including headache, dizziness, insomnia, restlessness, depression, and anxiety.

[17] A build-up of clear bodily fluids in a place on the body where tissue has been removed by surgery.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

She was told that she was booked into the registrar clinic, but Dr C would also be in clinic if there were any questions the registrar could not answer.

95. Ms A said that she waited almost two hours and, when she realised how fatigued and sore she was becoming, she tried to reschedule the appointment, but was told that the next available appointment was not until the end of June. She said that eventually when she was reviewed by Dr C, he appeared surprised at her condition. Ms A said that Dr C told her that the operation had been a 'success', asked whether she had lodged a treatment injury claim with ACC, and commented that the collection was unlikely to be a seroma and was more likely to be a collection of fluid from a wash-out.

96. Dr C told HDC that Ms A told him that her neurological impairment had improved significantly. He said that when he performed a neurological examination, Ms A had difficulty walking[18] and had fine movement impairment[19] in both hands. However, he stated: 'Overall, there was a remarkable improvement of the neurological deficits.'

97. In the clinic letter from this visit, dated 29 April 2019, Dr C states that Ms A had normal bowel and bladder function. However, Ms A said that this is incorrect, and she told him that she still suffered from very slow urinary flow and the need to 'double void', and that her bowels continued to need to be managed with a combined voluntary and reflex bowel regimen. She said that she felt that Dr C did not listen to her.

98. Health NZ Southern apologised for the prolonged wait time in the postoperative clinic and said that this reflects the imbalance between the available clinic resource and the clinical demand at the public hospital.

ACC

99. On 5 June 2019, an ACC treatment injury claim was made by Dr F in relation to Ms A's deterioration of neurological symptoms. ACC obtained treatment injury advice from neurosurgeon Dr H, who noted that Ms A presented with subtle evidence of cervical myelopathy, which was confirmed by the MRI scan.

100. In relation to the first spinal surgery, Dr H advised:

> 'In my view, [Ms A] did suffer, probably unintentional, personal injury (treatment injury) occurred within the context of "surgery", as evidenced by postoperative radiological investigation showing that there was a residual disc material, compression of spinal cord and thecal sac as seen in the preoperative scan indicating the first operation did not decompress the spinal cord compression that required a second operation. She also showed clinical deterioration soon after the first operation.'

[18] An ataxic gait.

[19] A lack of ability to use the small muscles.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

101. Dr H stated that the postoperative MRI scan showed residual disc material, and the degree of spinal cord compression was the same as seen in the preoperative scan, 'suggesting there was surgical failure to achieve a desired outcome and success'.

102. In relation to the second spinal surgery, Dr H advised that there was no evidence to suggest that a personal injury had occurred following that surgery.

103. On 26 October 2019, Ms A's ACC treatment injury claim was declined. ACC had not received a response from Dr B, so Dr H had been asked to comment on her case.

Health NZ Southern's response to Ms A's complaint — May 2019 to November 2020

104. Initially, Ms A complained to Health NZ Southern on 27 May 2019 about her experiences, and on 24 March 2020 she provided additional information to Health NZ Southern.

Response by the CMO

105. On 4 July 2019, Health NZ Southern's then Chief Medical Officer (CMO) wrote to Ms A. He said that he agreed about the critical importance of documentation and stated:

> 'The challenge is that there is a custom and practice that does not meet an acceptable standard and then resident medical officers take their cue from this. In our case I do agree that the documentation at the time of your admission is below an acceptable standard.'

106. The CMO said that he would advise Dr B of this and that there would be future audits of documentation in the neurosurgery service until the CMO was satisfied that a reasonable standard had been met.

107. It is noted that Health NZ Southern told HDC that as at October 2021, no documentation audits had been completed.

108. The CMO told Ms A that the lack of a formal operation note is not what he would expect. However, he said that neurosurgical operation notes are now typed and placed on the clinical intranet in most instances, and the service will ensure that its administrator is aware of this expectation and remind the medical staff that this is the expected practice for all patient operations.

109. The CMO said that Health NZ Southern is securing an IT system to support the surgical booking, documentation, and quality processes. That process is ongoing, and as yet there have been no changes as Health NZ Southern has not yet introduced scOPe (the system used in other South Island regions). Introducing scOPe requires adoption of the South Island regional patient administration system, and the work to do this is underway.

110. The CMO told Ms A that, in his view, the underpinning issue that led to many elements of her poor experience of care is a cultural one within the public hospital. He stated:

> 'We have committed to the "speak up" programme and work to reverse the negative atmosphere that has built up over many years. This is not a thing that can be changed

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

immediately but we are committed to making it better each day, month and year. There has been signs of improvement in that our formal survey completed recently for the second time does show improvements in almost all of the measures. This is only a start and there is still a lot to do.'

111. Health NZ Southern told HDC that two engagement surveys had demonstrated improved engagement at the public hospital.

Health NZ Southern follow-up of complaint and appointment with Dr B

112. Ms A said that (in approximately August/September 2019) she attempted to obtain an appointment with Dr B (as Dr C was no longer available) to obtain relevant information regarding their discussions and operative findings as required by ACC. She said she called into neurosurgery out-patients twice and rang three times. She was offered an appointment with a locum neurosurgeon, but she explained to the neurosurgery administrator that the appointment needed to be with someone involved in her surgery if she was to obtain supporting documentation for ACC. An appointment with Dr B was scheduled for 27 September 2019.

113. On 19 September 2019, the Medical Director of Surgical Services and the Radiology Directorate contacted Ms A and said that an external investigation of her treatment was being conducted because her GP had submitted an ACC treatment injury claim. Ms A said that she was invited to a meeting, as they were finding it very difficult to piece together from her notes what had taken place. She agreed to a meeting but said that it would be best to wait until after her outpatient appointment on 27 September 2019.

114. Ms A said that she found the appointment on 27 September 2019 very unsatisfactory as Dr B made several statements that were not accurate. She recalled that during this appointment, he claimed that prior to her first surgery they had a discussion during which he remembered her discussing the garden incident. However, Ms A's recollection is that this discussion was actually after the first surgery, as she did not meet Dr B prior to the first surgery. Ms A also stated that Dr B said that he was present during her second surgery, which was performed by Dr C. However, the surgical notes do not record Dr B being present during the second surgery.

115. Ms A said that on 7 October 2019 she attended a meeting with three managers. It was discussed that the investigation would likely take several months, and that Ms A's neurosurgical care would be transferred to Christchurch.

116. The Clinical Incident Report outlined that following this meeting, as Ms A had lost faith in the Neurosurgical Department, her on-going care was, with her permission, transferred to a neurosurgeon in Christchurch.

117. Ms A said that she contacted the three managers on 14 April 2020 to find out whether they were still actively investigating her concerns, as she had had no contact from any of them in six months. She said that she received no response from any of them. She rang one of the managers on 2 June 2020, and he was surprised that no one had replied to her previous email, and he said that he would chase it up and get back to her. The following day he replied

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

that they would conduct the investigation the following week and respond to her the week after that. However, this timeframe passed with no reply or update as to when she might expect the report.

118. Ms A stated:

> 'Firstly, I appreciate (more than most) the impact that COVID 19 has had on our health system during 2020 but the complete lack of any communication regarding this investigation is unacceptable …'

119. Health NZ Southern apologised to Ms A for not keeping her well informed about progress with the investigation.

Clinical Incident Report — 27 November 2020

120. The Clinical Incident Report dated 27 November 2020 outlines the events and care provided to Ms A. The report found the following:

1. Documentation of Ms A's injury was not recorded, although she remembers telling staff.
2. There was a change of date for surgery multiple times.
3. Preoperative discussion with the surgeon was affected by premedication, and although consent was obtained earlier, this was not by the operating surgeon. The operating surgeon had not signed confirmation of the consent.

121. The Clinical Incident Report recommended the following:

1. Documentation of any injury must be recorded.
2. Consent must be obtained before premedication. If the surgery is delayed or the surgeon changed then consent must be confirmed.
3. Change of surgeon after consenting must be communicated to the patient by the surgical team and it must be confirmed in writing that this has occurred.

Further comment from Health NZ

122. Health NZ stated that the documentation policy 'Health Record Documentation Standards (District)' has been distributed to the neurosurgery team to remind them of expected standards when documenting in patients' records.

123. Health NZ acknowledged that clear and concise documentation is imperative for the patient record to ensure safety and accurate records of patient assessment.

124. Health NZ said that there was understaffing at the time of these events. The Health NZ Southern neurosurgery service is now working more collaboratively with the Christchurch neurosurgery service as part of the 'One Service, Two Sites' model of care. It continues to recruit to the Health NZ Southern site and has developed a thorough orientation plan for new neurosurgeons in conjunction with a six-month assessment period at the Christchurch

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

site to ensure that any new neurosurgeons understand the New Zealand hospital environment in a structured and supported way.

Further information from Ms A

125. Ms A said that her patient journey experience has left her 'traumatised, with compromised physical health and uncertainty around future employment'. She stated that her overall impression is one of time-pressured staff and extremely poor communication within the treating team and with the patient, which was evident at every point.

126. Ms A said that she is very concerned about the standard of documentation, and she finds it inconceivable that surgical and post-surgical notes are not available for the surgeries that she had at the public hospital. She stated that with fragmented senior/surgeon staffing, not only is documentation important but actually listening to the patient is vital.

127. Ms A also feels that the lack of communication regarding Health NZ Southern's investigation was unacceptable.

Responses to provisional decision

Ms A

128. Ms A expressed her disappointment with Dr B's response regarding her care, and she feels that there has been no concession that there may have been communication and documentation errors. She stated:

> 'I think it speaks volumes, that … I found it necessary post-surgically to have a colleague attend all out-patient appointments with me, as I felt I was not get[ting] transparent communication from the Neurosurgery team members… I believe [Dr B] should have been modeling good patient-centered care and that truthful and transparent communication is part of this.'

129. Ms A recalls being picked up for theatre sometime after 7.00am on 4 February 2019 and being first on the surgical list. She noted Dr B's differing recollection of events and stated:

> 'Initially he had stated that he met me on the ward prior to my first surgery [see above paragraph 114] but I was at home on leave during this period (and I had been told he was overseas) and only came back to hospital on the evening of the 3rd of February. Secondly, when SDHB were investigating my case, he had stated that he met me in theatre, but I didn't remember as I had been given pre-medication and thirdly that I was 4th on the list, so he and [Dr D] could talk to me prior to surgery.'

130. Ms A referred to the anaesthetic record that supports her statement.

131. Ms A acknowledged that the outcome of this investigation will make no difference to her own patient journey and stated that the only reason she has pursued this matter (knowing the impact it can have on clinicians) was to prevent potential harm for other patients.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Health NZ Southern

132. Health NZ Southern was given an opportunity to respond to the provisional decision. Health NZ Southern advised that it accepts the proposed recommendations.

133. Following Dr B's response to the provisional decision, Health NZ Southern was asked to provide further information on any premedication given to Ms A. Health NZ Southern advised that there is no record of administration of premedication.

Dr B

134. Dr B was given an opportunity to respond to relevant sections of the provisional decision. His response has been incorporated into this report where relevant. Dr B denies that the discussion and his introduction to Ms A, as the surgeon who would be performing her operation, took place when she was under the influence of premedication. He categorically disputes that this would have occurred, as it is not in line with his usual practice. He stated that this was a suggestion made by Health NZ as a possible explanation for Ms A's lack of recall, and it was equally possible that the busy operating theatre environment and subsequent provision of premedication after the discussion took place was the cause.

135. It is Dr B's view that it is standard practice for surgical consent to be completed by a member of the team who is not always the operating surgeon, and that consent was provided by Dr E appropriately on 29 January 2019. He stated that the conversation introducing himself as the operating surgeon took place at an appropriate time prior to the surgery.

136. Dr B expanded on this statement saying that Dr D was not on duty on the day of Ms A's surgery, and therefore 'the discussion that [Ms A] recalls with him could not have happened on the day of surgery but rather prior to the day of surgery'.

137. As noted above, Ms A does not recall a meeting with Dr B and Dr D.

138. Dr B explained that a request was made for Ms A's procedure to be moved from 1 February 2019 to 4 February 2019 so that he would have the opportunity to meet with Ms A prior to her surgery.

139. Dr B acknowledged that his notes were insufficient and stated that he will take care to improve this in future.

Opinion: Health NZ Southern (previously Southern District Health Board) — breach

Introduction

140. Ms A had a difficult patient journey. It is understandable that she feels let down by the public hospital. I express my sympathy for the frustration and distress that she experienced.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

141. As a healthcare provider, Health NZ Southern was required to provide Ms A with services in accordance with the Code of Health and Disability Services Consumers' Rights (the Code) and had overall responsibility for service delivery in this case. I am concerned about three key aspects of the care provided to Ms A, namely around informed consent, record-keeping, and Health NZ's response to her complaint. I discuss these issues below.

Informed consent

Dexamethasone — breach

142. On 13 February 2019, Dr E prescribed the corticosteroid dexamethasone for three days. Ms A said that the administration of steroids was never discussed with her.

143. Dr E stated that whenever he prescribed dexamethasone while working in the neurosurgery service, it was a consequence of having been given express instructions from the responsible consultant. However, there is no evidence that Dr C gave such an instruction. There is no record of any such order.

144. Dr E cannot remember whether he, or any other member of the team, discussed with Ms A her treatment with dexamethasone. He noted that if there were any such discussions, they are not documented.

145. In light of the lack of documented discussion, Dr E's inability to recall whether it was discussed by him or any member of the team, and Ms A's recollection that the steroid was never discussed with her, I find it more likely than not that Ms A did not receive information about the prescription and administration of steroids and the potential risks, which she needed to make an informed choice.

146. Right 6(2) of the Code states that before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

147. I am unable to establish whether an instruction was given to Dr E by Dr C, or whether there was any consideration of the reasons for prescribing dexamethasone or the associated side effects or risks. There is no documented discussion, and Dr E is unable to recall whether it was discussed with Ms A by him or any member of the team. In my view, in the context of this case, this is an error for which Health NZ must take responsibility. I consider that this reflects the pressured environment in the service, and as Health NZ had overall responsibility for the service provided, and therefore this aspect of Ms A's care, I find that Health NZ Southern breached Right 6(2) of the Code. It follows that Ms A did not give informed consent to the administration of dexamethasone, and therefore that Health NZ Southern also breached Right 7(1) of the Code.

Record-keeping — breach

Preoperative records

148. On 29 January 2019, Ms A attended a pre-admission clinic as she was to undergo an ACDF the following day. Dr D stated that he went through her history and conducted an

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

examination. However, there is no comprehensive neurological examination recorded in the notes, and only an abbreviated clinical assessment is documented.

149. My clinical advisor, neurosurgeon Dr Wickremesekera, was critical of the standard of documentation of the preoperative assessment, as no preoperative documentation is recorded and there are no dictated clinic letters written by the neurosurgeons. He noted that only short written notes were documented by Dr E.

Operation notes and postoperative care

150. Dr E hand wrote operation notes for the 4 February 2019 surgery but there are no operation notes dictated by Dr B. Dr E said that there would not have been a typed note to accompany the handwritten operation note as it was not the practice in the department for the surgical team to have formal notes typed to accompany handwritten operative notes. Dr B and Dr C concurred. Dr Wickremesekera said that the absence of dictated operation notes by the neurosurgeons or registrars is inadequate and below the accepted standard of care.

151. Dr Wickremesekera advised that there is little documentation of the information given to Ms A about the reasons why the first procedure was unsuccessful and why the second procedure was necessary. Furthermore, there is a lack of documentation of discussions about Ms A's postoperative management under the supervision of the neurosurgeons. There are records of only two postoperative visits during the admission, and one follow-up clinic review while Ms A was at the spinal unit. In relation to this, Dr E said that while he could imagine that there may have been poor documentation of any consultation, registrars in the department generally speak to the consultants very frequently about postoperative patients under their care. Dr Wickremesekera advised that the paucity of documentation is inadequate and does not meet the accepted standard of care.

152. There is no documented communication between Dr C and Dr B. Dr C stated that this reflected the situation in the department at the time, and due to different schedules, he and Dr B did not see each other often and he could obtain a picture of the treatment strategy only from the clinical notes of the registrars. However, Dr C said that he did inform Dr B of the care and current management plan prior to the first surgery.

153. Dr Wickremesekera advised that a recommendation for improvement would be for the records to be in a dictated typed form, with well summarised documentation of the postoperative ward rounds with the senior registrars.

154. Dr Wickremesekera concluded that there was a moderate departure from the standard of care, and that overall, peer review would likely indicate that the systems and processes were inadequate and likely to reflect an under-resourced system in terms of time, teaching, and documentation.

Conclusion

155. Dr E said that the very heavy workload in the department may have contributed to the lack of documentation of Ms A's care.

156. The CMO agreed that documentation is critically important and told Ms A:

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

'The challenge is that there is a custom and practice that does not meet an acceptable standard and then resident medical officers take their cue from this. In your case I do agree that the documentation at the time of your admission is below an acceptable standard.'

157. Health NZ Southern acknowledged that clear and concise documentation is imperative for the patient record to ensure safety and accurate records of patient assessment.

158. I agree that the documentation is well below the expected standard and, in some aspects, non-existent. I note that subsequent assessment of Ms A's treatments has been made extremely difficult largely due to the confusing and sometimes absent documentation. As set out in the Health and Disability Services (Core) Standards, consumer information must be accurately recorded, current, and accessible when required.[20] Good documentation is essential to maintain continuity of care and it appears that there were cultural and systemic issues within the Health NZ Southern neurology service. Accordingly, I find that Health NZ Southern breached Right 4(2) of the Code.

Response to complaint — adverse comment

159. As is evident from paragraphs 104 to 119 above, following Ms A's complaint directly to Health NZ Southern on 27 May 2019, she received:

- A response to her complaint from Health NZ Southern slightly over one month later on 4 July 2019;
- An update from Health NZ Southern that an external investigation of her treatment was being conducted, approximately two and a half months later on 19 September 2019;
- A meeting with Health NZ Southern, approximately two and a half weeks later on 7 October 2019, during which she was advised that the investigation was likely to take several months;
- No contact for approximately six months, until 14 April 2020 when she contacted Health NZ Southern to ask for an update, but did not receive a response;
- No contact for a further seven weeks until 2 June 2020, when she contacted Health NZ Southern for an update. She was told that they would follow up and get back to her, and the following day informed her that the investigation would be conducted the following week, and then they would respond to her the week after that, which would be approximately the week of 15–19 June 2020;[21]
- No further contact until 27 November 2020, when she was provided with the clinical incident report — being approximately five and a half months since the last contact, and 18 months since first making her complaint.

[20] Standard 2.9 in the Health and Disability Services (Core) Standards 8134.1.2:2008, current at the time of events.

[21] Ms A made her complaint to HDC on 25 June 2020.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

160. I accept that the CMO responded to Ms A's complaint in just over five weeks; however, thereafter Ms A was not provided with timely updates. There were two gaps of six months without contact from Health NZ Southern, although this was in relation to the internal investigation. I encourage Health NZ to learn from Ms A's experience in this regard.

Adequacy of surgery and postoperative care — other comment

First surgery and postoperative care

161. On 4 February 2019, Ms A underwent ACDF surgery performed by Dr B. A postoperative CT scan on 6 February 2019 and an MRI on 7 February 2019 showed a residual disc prolapse with persistent cord compression.

162. Dr Wickremesekera said that the decision to perform an ACDF was appropriate given Ms A's circumstances.[22]

163. The adequacy of the procedure performed is discussed below under the opinion relating to Dr B.

164. Dr Wickremesekera said that although Ms A's postoperative care was adequate and appropriate assessments were undertaken, he noted the inadequate documentation (discussed above).

Second surgery and postoperative care

165. On 13 February 2019, Dr C performed a C3, 4, 5 laminectomy. Dr Wickremesekera said that as Ms A had not improved after her first surgery, it was reasonable to perform a posterior decompressive laminectomy.

166. Dr Wickremesekera advised that the standard of the posterior laminectomy and the postoperative care were adequate. I accept this advice.

Informed consent for change of surgeon — no breach

167. Ms A's surgery on 4 February 2019 was undertaken by Dr B, instead of Dr C, who had had the consenting discussion with Ms A, and who Ms A understood would be performing the surgery. Dr B said that he met Ms A with Dr D prior to the surgery; conversely, Ms A said that she was not informed that Dr C would not be performing the surgery, and she was not introduced to Dr B.

168. At the time of these events, Health NZ Southern had a comprehensive Informed Consent policy in place (relevant sections are outlined in Appendix B), which set out in detail the obligations of providers involved in obtaining informed consent.

169. In my view, Health NZ Southern's expectations in respect of informed consent were clear, and the failure to communicate effectively with Ms A or to obtain her informed consent to the surgery was an individual clinical failing by Dr B for the reasons discussed in paragraphs

[22] Ms A had a soft tissue disc prolapse with cord compression mostly over the anterior thecal sac (the tube that surrounds the spinal cord).

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

178 to 183 below, and I do not consider that Health NZ Southern breached the Code regarding this aspect of informed consent.

Opinion: Dr B — adverse comment

Surgery — no breach

170. On 4 February 2019, Dr B performed Ms A's ACDF surgery. A postoperative CT scan on 6 February 2019 and an MRI on 7 February 2019 showed that Ms A had a large residual disc prolapse with persistent cord compression.

171. Dr Wickremesekera advised that the procedure was inadequate, as there was large residual disc prolapse causing cord compression that could be seen clearly on the imaging after the surgery. Similarly, the ACC advisor, Dr H, said that Ms A initially presented with subtle evidence of cervical myelopathy that was confirmed by the MRI scan, and that the postoperative MRI scan showed residual disc material, and the degree of spinal cord compression was the same as seen in the preoperative scan, 'suggesting there was surgical failure to achieve a desired outcome and success'.

172. Dr H advised that in his view, '[Ms A] did suffer, probably unintentional, personal injury (treatment injury)' as evidenced by the residual disc material and the degree of compression, which indicated that the first surgery did not decompress the spinal cord compression and required a second surgery. He also noted that Ms A showed clinical deterioration soon after the first operation.

173. Dr B considered that as there was no large residual disc after the first surgery, revising the ACDF was not the best option for Ms A. He said that Ms A was given time to improve after the first operation, and when her progress was static, she was offered further decompression (treatment of the compressed nerves) posteriorly, after discussion.

174. Dr B said that it was well known to spinal surgeons that the reason for operating on patients with myelopathy (compression of the spinal cord) would be to stop progression, but with no guarantee of improvement.

175. Ms A said that when Dr B saw her after the surgery, he told her that he could tell that her spinal cord had not been decompressed by the surgery, but as they had never met previously and she had not been consented for any other procedure, he did only the ACDF surgery.

176. I have carefully considered the opinions of Dr Wickremesekera and the ACC advisor. I note that the opinions provided around the inadequacy of the surgery related to the complication from surgery Ms A experienced, rather than a specific deficiency in the surgery performed, and I am mindful that these comments are made with the benefit of hindsight.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

177. This Office does not make findings of causation. It assesses the standard of care provided at the time it was provided, irrespective of the outcome. While I acknowledge the opinions regarding the adequacy of the decompression procedure, I consider that I cannot make a finding that there was a confirmed deficiency in Dr B's surgical approach or skill in performing the surgery on 4 February 2019. However, I encourage Dr B to reflect further on the opinions of the advisors, and I have made a relevant recommendation below.

Informed consent — adverse comment

178. In relation to the ACDF surgery, Ms A was consented by Dr C (and Dr E), who was originally scheduled to perform her surgery. It is clear that Ms A wanted to discuss the details of the ACDF surgery with the operating surgeon. At the pre-admission clinic (29 January 2019) Dr D discussed the options of conservative versus surgical management and informed Ms A of the complications that might occur during her surgery.

179. Ms A asked Dr D about his qualifications, and he told her that he was a fellow, not a consultant, and that Dr C would be operating on her. Ms A asked to speak to Dr C directly, and did so, before signing the consent form.

180. Ms A's surgery was postponed until 4 February 2019 and Dr B performed this instead of Dr C.

181. It is clear to me that the consenting process was completed adequately six days prior to the surgery occurring on 4 February 2019 and there is no dispute that the surgery was completed as consented. Dr B's decision to undertake only the ACDF as no other procedure had been discussed indicates to me that the surgical plan did not change. However, I am concerned about whether Dr B introduced himself adequately as the surgeon prior to undertaking the procedure.

182. In a joint statement to HDC, Dr B and Dr D initially said that they both met Ms A on the day of the surgery, and Dr B discussed the approach that would be taken during the surgery. Dr B and Dr D initially told HDC: '[Dr D] was there during this discussion pre-surgery and was there post-surgery.' Subsequently, Dr B told HDC that Dr D was not on duty on the day of the surgery, so this discussion occurred prior to the day of surgery. There is no documentation of this discussion.

183. In contrast, Ms A said she did not know that Dr B was the surgeon until he told her after the surgery, and she was not introduced to Dr B prior to the surgery. Ms A said that Dr B told her that he could tell that the spinal cord had not been decompressed by the surgery but, as they had never met previously and she had not been consented for any other procedure, only the ACDF was done.

184. Health NZ Southern said that the reason why Ms A does not recall the conversation with Dr B may have been either due to the effects of the premedication she had received or the busy operating theatre environment. As outlined above, in his response to my provisional decision, Dr B disputed that Ms A would have been under the influence of premedication. He said that this was not his standard practice, and he would not have a conversation of this

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

sort with his patient after the premedication had been given. Health NZ Southern was asked for further information, and it confirmed that there is no record of Ms A being given premedication.

185. Informed consent under the Code is a process with three essential elements: effective communication between the parties (Right 5); the provision of all necessary information to the consumer (Right 6); and the consumer's freely given and competent consent (Right 7).

186. As stated by this Office previously,[23] except in an emergency, it is not good practice to provide information within a short timeframe prior to the procedure for which consent is sought:

> '… particularly in cases where the procedure is not urgent, as this does not allow adequate time for reflection. Furthermore, if the patient has already chosen a particular procedure, he or she may be less attentive to the information provided.'

187. The Health NZ Southern Informed Consent policy (outlined in Appendix B) provides that communication must occur in an environment that enables all parties involved to communicate openly, honestly, and effectively (per Right 5(2) of the Code). It states that in general, the person who is to perform the healthcare procedure is the one to gain consent from the consumer, although the responsibility for gaining consent may be delegated to another member of the healthcare team. This person must have sufficient knowledge and experience of the procedure to assess whether the consumer has been adequately informed, and to answer any further questions about the procedure or refer these to an appropriate member of the team.

188. The Informed Consent policy provides that the patient must be told the name of the person who will be undertaking the procedure where this person is different from the person who obtained the patient's consent. The Informed Consent policy also states:

> 'There is a presumption that the patient will be informed about who, specifically, will be performing the procedure — and that if the patient is not so informed, the person responsible would need to be able to identify good reasons why it wasn't necessary to inform the patient of this detail.'

189. Regardless of what Dr C said to Dr B, it was Dr B's responsibility to ensure that appropriate informed consent was obtained. In my view, Ms A should have been informed of who would be performing her surgery, especially as she had indicated that this was a matter of significance for her.

190. Both Dr D and Dr B said that a meeting took place, but Ms A does not recall it and there is no mention of it in the records. Based on the recollection of the two doctors, I consider it likely that a meeting, albeit briefly, took place.

[23] See Opinion 14HDC00307.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

191. The issue then is when this meeting occurred. Dr B has stated in his response to my provisional decision that he requested a change in the operating day from 1 February 2019 to 4 February 2019 so that he would have the opportunity to meet with Ms A, and as Dr D was not working on 4 February, the meeting therefore occurred prior to the day of surgery.

192. This is different to Dr B and Dr D's statements provided to HDC on 1 October 2021. Dr B and Dr D's joint statement includes the following:

> '[Dr C] was not available to operate on [Ms A] on 4 February 20[19]. [Dr C] discussed [Ms A] with [Dr B] and requested [Dr B] to perform the surgery. [Dr B] requested that [Ms A] be moved from 1st on the list to 4th on the list so he would have opportunity to meet with [Ms A] prior to her surgery.'

193. If Dr B had requested a delay of three days so that he could meet with Ms A and introduce himself, there would have been an opportunity to arrange a meeting prior to the morning of the operation. However, there is no record of a meeting between Dr B and Ms A in the days prior to her surgery. Initially, Ms A was scheduled for surgery on 30 January but was told by Dr C that she could take overnight leave as his earlier surgeries had run over time, which suggests to me that he was still the surgeon at this point. In addition, Ms A was on leave and at home between late afternoon on 31 January 2019 and 8pm on 3 February 2019. This is supported by the clinical record. It is also more likely that Dr B had requested, or intended to request, a change to the list order and timing of the operation on 4 February 2019 and that this did not occur, as her surgery commenced on or around 8.15am that day.

194. I therefore find it more likely that the meeting between Dr B and Ms A occurred on the day of, and just prior to, her surgery. As Ms A was first on the theatre list (as supported by the anaesthetic record), not fourth, it is also likely that the meeting occurred in less desirable circumstances than planned.

195. On the day of surgery, Ms A would have had a window between approximately 7am and 8.15am to be transferred from the ward to the theatre complex; be handed over to theatre staff; complete anaesthetic checks (including the surgical safety check list 'sign in' procedure); discuss and sign the anaesthetic consent; have an IV canula inserted; be transferred onto the operating table; and be anaesthetised.

196. The operation note stating 'marked using anatomical landmarks' indicates that Ms A was seen by at least one member of the neurosurgical team prior to surgery, although I am unable to determine who this was.

197. While Health NZ Southern's clinical incident report states that the effects of premedication may have affected Ms A's recollection, there is no record that any premedication was given, and therefore I accept that this was not a factor.

198. In making my decision I have considered the evidence of contact with a neurosurgical team member documented in the clinical record, the joint statement submitted by Dr B and Dr D, Ms A's recollection of events, subsequent statements made by Dr B, and the findings of Health NZ Southern's clinical incident report.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

199. It is my opinion that any meeting that occurred to inform Ms A of the change in surgeon and introduce Dr B would have been brief and in an environment that was not conducive to allowing Ms A time to consider this information. I agree with the incident report findings that this discussion was 'too late and not in line with Health New Zealand|Te Whatu Ora Southern policy'. I consider that it was inappropriate to undertake such a discussion while Ms A was in the operating theatre, immediately prior to her surgery.

200. I am critical of the manner in which Ms A was introduced to Dr B. I consider that the introduction was inadequate and did not meet the organisation's expectations.

Changes made

201. Health NZ Southern said that the following changes have been made since these events:

- At the end of surgery, handwritten operation notes are provided immediately to go with the patient to the post-anaesthesia care unit (PACU), as these handwritten notes form part of the immediate postoperative care instructions for the PACU nursing team. The handwritten operation note is scanned and filed on the clinical intranet so that anyone caring for the patient has immediate access to it. A more detailed operation note is dictated, typed either on the day of surgery or the day after, and uploaded in the electronic record. It is now standard practice for all patients to have a typed operation note.
- The dictation system has changed to enable clinicians to use their smartphone to dictate their letters. The system can mark the dictation as urgent (stat), which then is immediately prioritised for the typists.
- The documentation policy 'Health Record Documentation Standards (District)' has been distributed to the neurosurgery team to remind them of expected standards when documenting in patients' records.
- The Health NZ Southern neurosurgery service is now working more collaboratively with the Christchurch neurosurgery service as part of the 'One Service, Two Sites' model of care. Recruitment has continued for the Health NZ Southern site.
- An orientation plan for new neurosurgeons has been developed in conjunction with a six-month assessment period at the Christchurch site, to ensure that any new neurosurgeons understand the New Zealand hospital environment in a structured and supported way.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Recommendations

Dr B

202. In my provisional opinion, I recommended that Dr B review his complication rates for decompression surgery against those of his peers, and report to HDC on the outcome of this review and any relevant actions taken as a result of the review. This recommendation has been completed and a report was provided on 27 October 2023.

203. I recommend that Dr B undertake HDC's e-learning module on informed consent processes and provide evidence of completion of this training within three months of the date of this report.

Health NZ Southern

204. I recommend that Health NZ Southern:

a) Within three weeks of the date of this report, provide a letter of apology to Ms A for its breaches of the Code. The apology is to be sent to HDC for forwarding.

b) Within six months of the date of this report:

- Review neurosurgery service staff training regarding the informed consent policy, specifically noting that informed consent is not a one-off process but needs to be obtained when changes to plans occur, and provide HDC with evidence of this review.
- Audit the standard of record-keeping in the neurosurgery service and provide HDC with evidence of the outcome of the audit.
- Report to HDC on progress with securing an IT system to support the surgical booking, documentation, and quality processes and the introduction of scOPe. In response to the provisional opinion, Health NZ Southern stated: 'While we remain committed to introducing a suitable digital system as scOPe to support our surgical teams with documentation, owing to changes being undertaken in Health New Zealand|Te Whatu Ora at a national level, advice from our Digital Team is that bringing in such a system will be a national level decision and that discussion will not commence until a national digital structure for Health New Zealand|Te Whatu Ora is established.'

Follow-up actions

205. A copy of this report with details identifying the parties removed, except Health NZ Southern and the independent advisor on this case, will be sent to the Medical Council of New Zealand and Health New Zealand|Te Whatu Ora, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from neurosurgeon Dr Agadha Wickremesekera:

'Complaint: [Ms A]/Southern District Health Board

Our ref: 20HDC01118

Thank you for your letter dated 17 June 2021. [Ms A] presented with numbness and tingling affecting her upper limbs after an accident in December 2018 where she attempted to stop a [large object from falling]. Since then she had progressive numbness and weakness of her upper limbs with mild disturbance of gait. She was investigated by the neurologist and seen in clinic on 16 January 2019 with MRI on 21 January 2019 showing a C3/4 soft tissue disc prolapse with cord compression and early T2 signal change within the cord consistent with myelomalacia. She was referred to the neurosurgery service. She was admitted under the neurosurgery service from 30 January 2019 to 20 February 2019. Following ward assessment she undertook a C3/4 anterior cervical discectomy with fusion with placement of an anterior cervical plate on 04 February 2019. Following this procedure there was no obvious improvement, and in fact there appeared to be worsening with weakness. Post-operative CT on 06 February 2019 and MRI on 07 February 2019 showed the presence of large residual disc prolapse with persistent cord compression. She was returned to theatre on 13 February 2019 and had a C3, 4, 5 laminectomy performed by a second surgeon. Thereafter she remained with moderate lower limb disability as well as an indwelling catheter with mild weakness of her upper limbs, gait disturbance and pain. She was transferred to [the spinal unit] on 20 February 2019 and following a period of rehabilitation was discharged on 20 March 2019. During this period she showed steady improvement with residual mild weakness and unsteadiness towards the latter part of March but had undertaken a driving test under the occupational therapist and deemed fit to drive.

In terms of your questions it was appropriate to undertake the decision to perform anterior cervical discectomy and fusion. She had a soft tissue disc prolapse with cord compression with compression mostly over the anterior thecal sac.

The procedure that was undertaken on 04 February 2019 was inadequate as the patient did not improve and there was clearly residual disc prolapse causing cord compression seen on the imaging after this surgery.

The post-operative care provided on the ward and junior medical staff was adequate and appropriate assessments were undertaken. There is a paucity of consultation with the neurosurgeons.

Following the imaging showing residual disc prolapse it was reasonable to perform a posterior decompressive laminectomy given that the patient did not improve after the first surgery. There was also the better option of revising the anterior procedure and

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

removing the anterior disc prolapse and dividing the posterior longitudinal ligament, however posterior approach is not unreasonable.

The care provided during the posterior laminectomy on 13 February 2019 was adequate. The post-operative care was adequate following the second procedure.

The operation notes were written by the registrar. The registrar performed good consent processes documenting the risks. However there is an absence of dictated operation notes by the neurosurgeons or registrars, which is inadequate and below the accepted standard of care.

In addition there is inadequacy of documentation of the preoperative assessments, again as I was not able to find dictated clinic letters. There are short written notes documented by [Dr D] and [Dr E] the junior staff which is rudimentary.

There was a good preoperative clinic letter from the neurologist but I was not able to find adequate preoperative documentation or clinic letters by the neurosurgeons.

It appears that the procedures were discussed with the patient with adequate documentation and the preoperative consent forms provided by the hospital. There was no mention of the detailed prescription of dexamethasone.

In conclusion there are a number of inadequacies that do not meet the accepted standard of care. These include the initial ineffectiveness of the anterior cervical discectomy, paucity of documentation of information given to the patient in terms of why the first procedure did not work and the need for the second procedure. There is inadequate preoperative dictated clinic notes and written documentation by the two surgeons involved in the procedures. There is also no dictated operation notes by the neurosurgeons. Furthermore there was a paucity of documentation and discussion of the post-operative management under the supervision of the neurosurgeons as there was only documentation of two post-operative visits during the admission and one follow up clinic review whilst the patient was at [the spinal unit] where there was a documented letter from the neurosurgery clinic by the second surgeon.

Overall peer review would likely indicate that the systems and processes are inadequate and likely to reflect an under resourced system in terms of time, teaching and documentation.

Recommendations for improvement would be, to have adequate preoperative review of patients in the ward or clinic setting with documented dictated letters describing the patient findings, to have documented communication between the two neurosurgeons who dealt with this patient again preferably in a dictated typed form, to mandate dictated typed operation notes by the surgeons rather than short written notes by the junior staff, to have well summarised documentation of the post-operative ward rounds with the senior registrars, as well as documentation of the consultants seeing the patients at least two to three times a week following the surgery.

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

In this setting where there was a poor outcome after the first operation, there was a greater requirement and vigilance, in terms of explanations to the patient, and documentation with typed or detailed written form in the notes explaining the possible outcomes to the patient. Overall the findings suggest that there is a need for improvement of systems and major culture change, with documentation during an admission, the preoperative care, intraoperative care as well as post-operative management and documentation of explanations for the patient.

Addendum 6 December 2021

Thank you for all the rebuttal information. I have not found reasons to change my overall opinion. Understandably the replies are mostly defensive and have failed to account for the patient's complaints. Apart from one reply from one of the registrars, the rebuttals are neither constructive nor restorative. There are several areas that can be addressed for improvement. I enclose my original reply. I would conclude that there is a moderate departure from the expected standard of care. Please let me know if this reply is inadequate or requires further clarification.'

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B: Health NZ Southern informed consent policy

Health NZ Southern's 'Informed Consent for Health Care Procedures Policy' (March 2017) provides that communication must occur in an environment that enables all parties involved to communicate openly, honestly and effectively. It states that in general, the person who is to perform the healthcare procedure is the one to gain consent from the consumer, although the responsibility for gaining consent may be delegated to another member of the healthcare team. This person must have sufficient knowledge and experience of the procedure to:

- Assess whether the consumer has been adequately informed
- Answer any further questions regarding the procedure
- Refer consumer queries or concerns to an appropriate member of the healthcare team

The policy provides that the patient must be told the name of the person undertaking the procedure where this person is different from the person who obtained the patient's consent. The policy also states:

> 'There is a presumption that the patient will be informed about who, specifically, will be performing the procedure — and that if the patient is not so informed, the person responsible would need to be able to identify good reasons why it wasn't necessary to inform the patient of this detail.'

Names have been removed (except Health NZ Southern and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.