



Petition 2011/102 of Carmel Berry and Charlotte Korte

Interim report of the Health Committee

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Recommendation

The Health Committee has considered Petition 2011/102 of Carmel Berry and Charlotte Korte, and recommends the House take note of its interim report.

We have considered Petition 2011/102 of Carmel Berry and Charlotte Korte, requesting that the House of Representatives inquire into the use of surgical mesh in New Zealand. We have held two hearings of evidence, but will not have time in this Parliament to hear all the relevant evidence or to complete our consideration of this item of business.

The petitioners provided us with a great deal of evidence concerning adverse effects from the use of surgical mesh, and made specific recommendations for the coverage of a suggested inquiry into the use of surgical mesh in New Zealand, and for action they believe should be taken before an inquiry commences. Their recommendations include regulating more closely and monitoring the safety of surgical mesh medical devices used in New Zealand; introducing mandatory reporting of mesh-related adverse events by all parties in a position to do so; collecting more detailed information on the mesh devices used in New Zealand, and how they are used; creating a register of all mesh implant procedures carried out; conducting an audit of the standard of informed consent to undergo mesh procedures in New Zealand; and creating a register of surgeons properly trained and qualified to use mesh products, with an emphasis on mesh removal skills.

We heard from the MedSafe business unit of the Ministry of Health that surgical mesh should usually be used only where other treatments are not available or effective, so there should be an overall benefit to its use despite the comparatively high failure rate for some procedures. We heard it argued that an effective register can be difficult to implement, and that retrospective audits can be unreliable. We were told that a study directly comparing the results for two years following surgery of mesh and biological grafts in prolapse surgery is due to report in late 2014. We were also told that due to the small population of New Zealand it was necessary to use evidence from agencies in Europe and the FDA in the USA.

We heard from the Accident Compensation Corporation that it has agreed to meet regularly with Medsafe to discuss issues with medical devices used in New Zealand; that it would comply with any mandatory reporting requirement; that it will undertake a retrospective audit of claims with a surgical mesh component; and that its legislation requires it to assess such claims in the same way as any other treatment injury.

Gynaecologist Hanifa Koya and the Women's Health Action Trust each spoke in support of the petitioners. Emeritus Professor Don Wilson made the following more detailed recommendations in his written submission.

- That all surgeons using mesh be credentialled, as regards their training and ongoing experience, along lines proposed by the Urogynaecological Society of Australasia.

- That all “mesh” surgeons use the Urogynaecological Society of Australasia Pelvic Floor Database, which records all surgery and any complications, and also complete the proposed register.
- That any mesh complications be recorded using the International Urogynaecological Association’s classification, to allow comparison between surgeons worldwide.

We heard oral evidence from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Members of the college told us that for many conditions, traditional surgical approaches have had significant failure rates. When surgical mesh was used according to best practice for specifically indicated procedures, it was likely to lead to a better outcome than any available alternative. However, complication rates had to be taken into account. They agreed that such procedures should only be carried out by appropriately trained and experienced surgeons, and that a register of procedures and complications would be useful, if expensive.

We were particularly interested in their views on informed consent. We heard that the information given should be comprehensive (and ideally include feedback from other patients, if privacy issues can be avoided), but should not be delivered all at once, so the patient can take in the information at their own pace and have every opportunity to ask questions. Information should include full discussion of the severity and frequency of possible complications. Consent should be sought in writing, and include a summary of information already given.

We believe that this petition needs further consideration of all the evidence received so far, and that evidence should be sought from the Royal Australasian College of Surgeons. We ask that the Government take note of the recommendations reported above, and recommend that this item of business be reinstated in the new Parliament. A view should be reached on whether a final report on the petition would suffice, or whether a separate inquiry should be initiated or recommended.

Appendix

Committee procedure

Petition 2011/102 of Carmel Berry and Charlotte Korte was referred to the committee on 20 March 2014. We received written evidence from the petitioner and from the Accident Compensation Corporation, Hanifa Koya (gynaecologist), the Ministry of Health, Emeritus Professor Don Wilson, the Women's Health Action Trust, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. We heard oral evidence from the petitioner and from the Ministry of Health, the Accident Compensation Corporation, Hanifa Koya (gynaecologist), the Women's Health Action Trust, and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

Committee members

Dr Paul Hutchison (Chairperson)
Shane Ardern
Paul Foster-Bell
Kevin Hague
Hon Annette King
Iain Lees-Galloway
Scott Simpson
Barbara Stewart
Poto Williams
Dr Jian Yang