Speech for Medico Legal Society 2 September 2003

Auckland District Health Board Body Parts, Tissues and Substances Review Panel, also known as the Bits and Bobs Committee

This panel, which I chaired, came directly out of the publicity that Dr Warren Smith has referred to in regard to the Greenlane Heart Collection. Following that publicity, the Board did a review of all of its premises to ascertain what other body parts or tissues were being retained.

As it turned out, there was a very significant amount, including amputated limbs, livers, skull bone flaps, skeletons for teaching and countless specimens and tissue slides.

The Review Panel was set up specifically to decide what should be done with the already retained items and set out future practice.

The membership of the panel reflected a wide range of highly competent people. Dr David Sage, who is the Chief Medical Office for Auckland District Health Board, chose the panel and was also a member of the panel. The other members were Dr Sandy Dawson, representing the Ministry of Health; Dr Jan Crosthwaite, an Ethicist at the University of Auckland; Jo Fitzpatrick, a consumer from Women's Health Action; Dr Tim Koelmeyer, a pathologist; Mr Jonathan Koea, surgeon, Raewyn Wolcke, General Manager of Quality and Safety for Auckland Hospital; Mia Carroll, director of Nursing; Dr Colin McArthur, medical advisor for quality and safety and also an anaesthetist and intensivist; and Peter Le Cren, legal advisor. Believe it or not, we reached consensus in regard to all the key issues.

It is not possible in two or three minutes to deal with the detail or complexity of the issues the panel dealt with. What I intend to do is summarise the key findings we made, which have now been applied to practice.

Our modus operandi was to first discuss extensively and agree a set of principles. The first decision we made was that there was a clear differential value for the community in terms of whole organs as compared to tissue samples or substance samples.

There is a real emotional distinction to be made in regard to the distress at the retention of a heart or a brain, which is understandable, but the same cannot be said about samples of human tissue, which would scarcely be recognisable as such if they were stored.

In general there is even less emotional distress caused by the retention and disposal of substances which are basically urine, faeces and blood.

. In addition the distinction needs to be drawn for sheer practical reasons.

Any proposal to obtain full informed consent for the removal, retention or disposal of substances on every occasion, in a busy hospital is simply unworkable. For example the sheer number of blood samples taken alone makes the concept impractical but we also thought unnecessary and undesirable

This may seem self-obvious but the distinction remarkably is not drawn in the Code of Health and Disability Services Rights. One of our panel's recommendations is that the Code of Rights, when it is next reviewed, should differentiate between substances, body parts and tissues. The code does not apply to deceased persons.

The second principle we reached was that the consent process should be basically be the same whether the patient was living or deceased. That is a higher standard than the current law, which holds that the deceased body has no rights. However, we considered that the distinction between dead and breathing patients in this particular area was not supported by public expectation now. We recommended that the Human Tissue Act be reviewed and amended.

Once those principles were drawn, we reached the view that in the context of informed consent, there were two levels of applicable consent. Explicit consent, being written consent signed by the appropriate person and what we called informed acceptance which required the provision of information about standard procedures that a reasonable consumer would expect in the circumstances. That information will usually be provided in pamphlet form on admission. The opportunity to question and/or reject that information was also to be provided as part of informed acceptance.

Using those distinctions we developed a grid, which we tried to keep as simple as possible for ease of use.

In general terms, in regard to removal of body parts and tissue and the retention of body parts, explicit consent should be required. In regard to dealing with substances and retention and disposal of tissue, we considered that informed acceptance was sufficient consent.

In terms of the existing specimens retained, we recognised that there had been a significant change of acceptable practice in regard to dealing with the body and its parts. We took the view that the applicable practices must reflect this shift in sentiment in contemporary society but historical context meant that a distinction needed to be drawn. We drew the line in the sand at 5 August 1988, being the date of the release of the Cartwright Report. That was chosen as a date when a significant shift in regard to attitudes of informed consent was identifiable.

In regard to any body parts, tissues or substances retained prior to 5 August 1988 we considered that retention was acceptable without further consent.

We considered that in regard to body parts, any retained after that date would require explicit consent, if necessary contacting the patient or family to obtain that. If it could not be obtained the body part should be disposed of. Again however, we drew a distinction in regard to tissues and substances that could be retained if there were overriding public/individual patient interest, without further consent.

The issues that the panel had to deal with were extremely interesting in terms of moral, medical and legal complexity. We were conscious that Auckland was the first Area Health Board to look closely at this area of consent. We wanted to produce a practical working document to help clinicians and management on a day to day basis. The feedback from Auckland Area Health Board indicates that the report has met that expectation.