Southern District Health Board

A Report by the
Health and Disability Commissioner

(Case 19HDC02143)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman who presented to an Emergency Department (ED) with rectal bleeding on multiple occasions. The report highlights the importance of critical assessment when patients present to hospital on multiple occasions with the same symptoms within a relatively short period of time.

2. At the time of events, the woman was under the care of the Haematology Department at the public hospital (Southern District Health Board (SDHB)) as she was receiving chemotherapy for a relapse of cancer of the lymphatic system (lymphoma). The woman presented to the ED on 12 November 2018, 10 December 2018, and 27 January 2019 with rectal bleeding. She was admitted to the Haematology Ward during her first two presentations. Rectal examinations were carried out at all three presentations, and no masses were recorded. At the woman's first presentation on 12 November 2018, a general surgery registrar examined the inside of the woman's rectum and anus (rigid sigmoidoscopy) and carried out a digital rectal examination. The registrar recorded that views from the sigmoidoscopy were limited due to blood.

3. On 22 January 2019, the woman had an appointment with the Haematology Outpatient Clinic as part of her chemotherapy monitoring. The haematology consultant reviewed the woman's symptoms and blood test results and referred her to the gastroenterology team to consider a colonoscopy (an examination used to detect changes or abnormalities in the large intestine). On 25 January 2019, a gastroenterologist reviewed the woman's referral and advised that they would not pursue further investigation in an individual who had presented with two self-limiting episodes of rectal bleeding in the context of a thrombocytopenia (low blood platelet count) and a "normal sigmoidoscopy".

4. On 28 January 2019, the woman attended an appointment with her GP. The GP carried out a rectal examination and recorded an irregularity in the rectum. The GP made an urgent referral to a private gastrointestinal surgeon and endoscopist. On 8 February 2019, the woman was seen by the surgeon, who carried out a rectal examination. The surgeon felt a significant mass on the rectal wall, and a colonoscopy showed a large mass. The woman was later diagnosed with rectal cancer.

Findings

SDHB

5. The Commissioner considered that there were a number of deficiencies in the care the woman received across the three ED presentations: there was no specific follow-up to identify the cause and source of her bleeding at the woman's first and second presentations; there was no repeat investigation or referral to outpatient services following the inconclusive rigid sigmoidoscopy at the woman's first presentation, and this result was recorded inaccurately in the discharge summary; and the woman's family history of bowel cancer was not explored by any of the clinicians during her three presentations to SDHB.

6. The Commissioner considered that, ultimately, SDHB was responsible for the deficiencies in the services provided. She found that SDHB failed to provide services to the woman with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Recommendations

7. The Commissioner recommended that SDHB share this case anonymously to highlight the importance of: adequate rectal examinations; maintaining accurate patient records that reflect the care provided at each consultation, with full medical and family history notes; critically assessing patients who present on multiple occasions; and encouraging opportunities for teaching junior staff on what constitutes a good rectal examination, including its importance and limitations. The Commissioner also recommended that SDHB consider instigating a process where if a patient presents to ED but is an existing patient under the active care of another specialty, that specialty be informed during the presentation or at discharge.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint referral from the Nationwide Health & Disability Advocacy Service about the services provided by Southern District Health Board (SDHB) to Mrs A. The following issue was identified for investigation:

- *Whether SDHB provided Mrs A with an appropriate standard of care between November 2018 and January 2019.*

9. The parties directly involved in the investigation were:

Mrs A	Complainant/consumer
SDHB	Group provider

10. Further information was received from:

General practice	
General practitioner (GP)	
Dr B	General surgery registrar

11. Also mentioned in this report:

Dr C	ED house officer
Dr D	Haematology registrar
Dr E	Haematology registrar
Dr F	Haematology consultant
Dr G	Haematology consultant
Dr H	ED registrar
Dr I	Gastroenterologist

Dr J	Emergency medicine consultant
Dr K	Gastrointestinal surgeon and endoscopist

12. Independent expert advice was obtained from an emergency medicine specialist, Dr William Jaffurs (Appendix A), a haematologist, Dr Eileen Merriman (Appendix B), a general surgeon, Dr Mark Sanders (Appendix C), and a gastroenterologist, Dr Derek Luo (Appendix D).

Information gathered during investigation

Introduction

13. At the time of events, Mrs A (then aged in her sixties) was receiving chemotherapy for a relapse of cancer of the lymphatic system (lymphoma) and was under the care of the Haematology Department at the public hospital. She had a family history of colorectal cancer.

14. This report discusses Mrs A's management by the public hospital when she presented with rectal bleeding on multiple occasions.

First presentation 12 November 2018

15. Mrs A first presented to the Emergency Department (ED) on 12 November 2018 with rectal bleeding, and was admitted to the Haematology Ward.

16. Mrs A was seen by a haematology registrar, Dr D, who noted in the medical records that Mrs A had suffered a recent relapse of lymphoma and was undergoing chemotherapy for this. Dr D also noted that Mrs A had low haemoglobin levels (anaemia) and had prior issues with low platelet[1] numbers in her blood (thrombocytopenia). In the medical notes, Dr D included a plan for Mrs A to receive medication (tranexamic acid) to reduce her heavy bleeding, and a blood transfusion and intravenous (IV) fluids. Dr D recorded Mrs A's relevant episodes of rectal bleeding and her bowel patterns, but there is no mention of her family history of colorectal cancer.

17. Dr D checked on Mrs A later the same day and recorded that her platelets had increased but her haemoglobin had dropped slightly. He also noted that she had had three further rectal bleeds since admission, and asked for a surgical review.

18. A General Surgery registrar, Dr B,[2] assessed Mrs A and examined the inside of her rectum and anus (rigid sigmoidoscopy up to 15cm). This investigation allows the clinician to view the inside of the rectum by way of a camera. Dr B documented that "views [from the sigmoidoscopy were] limited due to blood lying", and that "no active bleeding [could be]

[1] Platelets help blood to clot, which stops bleeding.
[2] Dr B is no longer registered to practise in New Zealand.

seen however cannot be excluded". Dr B also carried out a digital rectal examination (DRE)[3] and recorded in the clinical notes that an external haemorrhoid[4] was seen but no masses were felt, and that blood on the glove was noted upon withdrawal. Dr B recommended a CT of the abdomen if Mrs A became unstable. Dr B recorded Mrs A's recent episodes of rectal bleeding, but did not mention her family history or change in bowel patterns.

19. Dr B told HDC that the purpose of the above assessment was to establish that Mrs A's blood flow was stable in an emergency care setting. Dr B acknowledged that she could have sought "a more detailed history and in particular family history could have been taken". Mrs A was reviewed on the Haematology Ward round the following morning, at which stage it was noted that there had been no further rectal bleeding. A note was made by the surgical team during the morning ward round that Mrs A's haematology team should "inform gastro[enterology] of bleeds". Mrs A was discharged and advised to return if she experienced further bleeding.

20. In relation to the sigmoidoscopy, the discharge summary stated: "Surgical review — no masses on PR,[5] rigid sigmoidoscopy showed blood in rectum but nil active seen up to 15cm." However, the discharge summary did not note that the views were limited and that active bleeding could not be excluded.

21. It is relevant to note that at Mrs A's subsequent visits to hospital (described below), the results of the rigid sigmoidoscopy were erroneously described by other clinicians as "normal". SDHB acknowledged to HDC that this was not what Dr B had described.

Second presentation 10 December 2018

22. On 10 December 2018, Mrs A again presented to the ED with rectal bleeding, and again was admitted to the Haematology Ward. Prior to her admission to the ward, an ED house officer (a junior doctor), Dr C, carried out a rectal examination. Dr C documented Mrs A's previous episodes of rectal bleeding and noted that on examination he found an empty rectum with no masses and a small amount of dark red clotted blood on the glove. However, there is no mention of Mrs A's family history or her change in bowel patterns.

23. The haematology clinical notes state that Mrs A had passed a small number of blood clots about 4cm in length. Mrs A was given another blood transfusion, including platelets, and tranexamic acid. A haematology registrar, Dr E, viewed Mrs A's blood test results, which included a low haemoglobin level of 86g/L.[6] Dr E documented that the main active problem was rectal bleeding in a setting of thrombocytopenia (low platelet count, meaning she was at risk of bleeding), and that Mrs A was anaemic. Dr E recorded Mrs A's medical history, including the date of her last chemotherapy, her recent bowel patterns, and that she had

[3] Examination of the rectum using a finger.
[4] An abnormal mass of blood vessels in swollen tissue that occurs either internally in the anal canal or externally around the anus.
[5] "Per rectum" — examination of the rectum using a finger.
[6] SDHB also provided Mrs A's blood test results from the previous week, which showed that on 3 December 2018 her haemoglobin level was 130g/L. The normal range is 130–175g/L.

experienced this type of rectal bleeding in the previous month (November), but she did not mention Mrs A's family history. Dr E referred to the rectal examination performed by Dr C in the ED, in which "nil masses" were found, and noted that Mrs A's haemoglobin was 86g/L — down from 130g/L the previous week.[7] Dr E also noted that after discussion with the haematology consultant, Dr F, it was considered that Mrs A did not currently need surgical review or another sigmoidoscopy as Mrs A was too thrombocytopenic to undergo a procedure at that point. Mrs A was discharged the following day. Her discharge plan included further blood tests and more tranexamic acid, and noted that a CT scan for her lymphoma had been planned previously.

24. In response to the provisional opinion, Dr F told HDC that on the morning of 10 December 2018, Mrs A's case was discussed at the haematology grand round with the entire haematology medical and nursing team. Dr F stated:

> "[T]he discharge plan included close follow up of [Mrs A] with nursing review, and to act on any further episodes of bleeding or any new patient concerns. As part of this nursing follow up, she was phoned by the haematology clinical nurse specialist (CNS) on 18 December 2018. It is documented in [the electronic medical record] that [Mrs A] reported no new concerns or bleeding, and knew to make contact if there were any concerns, and the haematology nurse discussed her case and blood counts with [the haematology consultant] [Dr G]."

Appointment with Haematology Outpatient Clinic 22 January 2019

25. Prior to Mrs A's appointment with the Haematology Outpatient Clinic, she had a blood test on 17 January 2019 as part of her chemotherapy monitoring. Mrs A's platelets had increased and were now within the normal range.[8]

26. On 22 January 2019, Mrs A was seen by haematology consultant Dr G in the Haematology Outpatient Clinic, for follow-up of her chemotherapy. Dr G reviewed Mrs A's symptoms and the blood test results from 17 January 2019. Dr G decided to refer Mrs A to the gastroenterology team to consider a colonoscopy. He stated in the referral letter:

> "[Mrs A] presented with two episodes of PR [rectal] bleeding while she was having chemotherapy. She had a sigmoidoscopy done which was normal. I would be grateful if you could consider her for a colonoscopy to ensure that she does not have any colonic lesions causing the recurrent bleeding."

27. A reply to the colonoscopy referral from gastroenterologist Dr I, dated 25 January 2019, advised that they would not pursue further investigation in an individual who has had two self-limiting episodes of rectal bleeding in the context of a thrombocytopenia that had been resolved at that time[9] and "a normal sigmoidoscopy". Dr I advised Dr G that there would be

[7] In response to the provisional opinion, Dr F commented that "a very significant amount of the decline in [Mrs A's] haemoglobin was due to her chemotherapy treatment, and not her rectal bleeding."
[8] Mrs A's platelets on 17 January 2019 were 170 x 10^9/L. The normal range is between 150–400 x 10^9/L.
[9] Platelet count at time of referral was 170 (normal).

an indication for colonoscopy if the patient had "iron deficiency anaemia or had persistent bleeding despite correction of her platelet count". In response to the provisional report, Dr I noted: "[T]he character of the bleeding was not outlined in [Dr G's letter] but, in order to respond to the referral, I did review previous correspondence and admission records in the electronic file." Dr I further explained that the reason he declined the colonoscopy was "the information available indicated anorectal bleeding, in the setting of a large haemorrhoid, a normal rectum and compounded by severe thrombocytopenia." Dr I considered the National Access Criteria for colonoscopy,[10] which indicates colonoscopy within six weeks where there is "unexplained rectal bleeding (benign anal causes treated or excluded)" where the patient is older than 50 years. Dr I said that his rationale for declining the colonoscopy was that a potential benign cause for Mrs A's bleeding had been identified (the haemorrhoid and thrombocytopenia), and therefore she did not meet the access criteria.

Third presentation 27 January 2019

28. On 27 January 2019, Mrs A presented to the ED for a third time. ED registrar Dr H assessed Mrs A and noted that she was experiencing rectal bleeding and that her stools were red. Dr H carried out a rectal examination and recorded that the rectum was empty, and that no fissures, masses, or external haemorrhoids could be found, no active bleeding could be seen, and there was no blood on the examination glove. After discussion with an emergency medicine consultant, Dr J, a referral was sent to gastroenterology for consideration of a colonoscopy. Mrs A was discharged home and asked to return if she experienced any further bleeding. Dr H's notes record that Mrs A had experienced similar episodes, but there is no mention of her family history or change in bowel patterns.

General practitioner appointment 28 January 2019

29. The following day, Mrs A attended an appointment with her GP. The GP carried out a rectal examination and recorded an irregularity in the rectum, which she believed was suspicious. She made an urgent referral to a private gastrointestinal surgeon and endoscopist.

Specialist appointment

30. On 8 February 2019, Mrs A was seen by gastrointestinal surgeon and endoscopist Dr K. Dr K carried out a rectal examination and noted: "I could feel a significant mass arising from the rectal wall about 5cm from the anal verge. The mass was occupying half the circumference." Dr K documented Mrs A's family history of colorectal cancer and arranged a colonoscopy for the following Wednesday.

31. Dr K carried out the colonoscopy on 13 February 2019. The colonoscopy report stated:

> "[T]he digital rectal exam revealed a hard rectal mass palpated 4.0cm from the anal verge ... A large mass was found in the distal rectum … The mass measured five cm in length. In addition, its diameter measured four cm."

[10] National access criteria included at Appendix D.

32. A biopsy of the tumour confirmed a diagnosis of rectal cancer.

Subsequent events

33. On 15 February 2019, Mrs A underwent an MRI scan. The findings noted a semi-ring-shaped tumour measuring 4.4cm in length within the mid rectum. Radiologically, the furthest (inferior) margin of the tumour was noted to lie 7.6cm from the anal verge.

34. On 10 July 2019, Mrs A underwent surgery to remove the mass. The operation note documented that the tumour was palpable on rectal examination 5cm from the anal verge, and that the tumour had reduced in size following chemo-radiation, but was still easily palpable.

Further information

35. In a letter to SDHB, Mrs A expressed her concerns regarding the care provided to her. Mrs A stated that while she had experienced 10 years of excellent treatment at the public hospital, the events complained about had had an impact on her trust in the system. Mrs A feels that there were multiple missed opportunities to find the tumour, and multiple chances to investigate her symptoms further, which led to her delayed diagnosis.

36. SDHB has acknowledged that despite rectal examinations, the tumour was not detected, and that accordingly no further investigations were undertaken. SDHB cannot say definitively why the tumour was not detected, but accepted that the rectal examinations should have been sufficient to diagnose Mrs A's tumour. SDHB is very sorry that this did not occur and that the opportunity to diagnose Mrs A's tumour at an earlier stage was missed. SDHB stated: "[T]he delay in diagnosis would seem to be due to the summative effects of a number of clinical decisions made by a number of different clinicians and this is deeply regretted."

Responses to provisional opinion

37. Mrs A and SDHB were given the opportunity to respond to relevant sections of my provisional opinion. Dr F and Dr I also provided comments on the provisional opinion. Where appropriate, their responses have been incorporated into this report.

38. Mrs A welcomes the advice from SDHB that it is undertaking a full review of the colonoscopy referral process. She stated that she would like a face-to-face apology from those who missed opportunities to diagnose her tumour. Mrs A reiterated the impact the delayed diagnosis had on her health. As a result of the delay, she had to have surgery to attach a stoma bag, which is now irreversible due to a relapse in her lymphatic cancer.

Opinion: Southern District Health Board — breach

Introduction

39. This case highlights the importance of critically assessing patients when they present to hospital on multiple occasions with the same symptoms within a relatively short period of time. Whilst appreciating that Mrs A was undergoing treatment for a relapse in lymphoma, which may have meant that she was a complex patient, I have concerns about the failure to fully investigate Mrs A's rectal bleeding. In particular, I am concerned about the lack of critical thinking at each presentation to question the cause and source of that bleeding.

Investigating cause of Mrs A's bleeding

40. In order to assess whether Mrs A received care of a reasonable standard on her three acute presentations (12 November, 10 December, and 27 January) I sought expert advice from ED specialist Dr William Jaffurs, general surgeon Dr Mark Sanders, and haematologist Dr Eileen Merriman. Each issue of concern is addressed below, with reference to my expert advice.

Lack of rigid sigmoidoscopy follow-up

41. At Mrs A's initial presentation on 12 November 2018, following referral to the surgical team for investigation of her rectal bleeding, the surgical registrar, Dr B, carried out a rigid sigmoidoscopy. Dr B recorded that views were limited because of the presence of blood in the rectum, and while no active bleeding could be seen, it could not be excluded. Mrs A's bleeding settled, and she was discharged on 13 November. No plans were included in the discharge summary for follow-up of Mrs A's symptoms either by colonoscopy or further sigmoidoscopy, notwithstanding the inconclusive sigmoidoscopy results. Additionally, there is no evidence that anyone from Mrs A's haematology team discussed her presentation with gastroenterology (specialists in rectal and colon management) as had been suggested by the surgical team at the morning ward round (and as recorded in the clinical notes). The discharge summary from Mrs A's first presentation on 12 November 2018 stated: "Surgical review — no masses on PR, rigid sigmoidoscopy showed blood in rectum but nil active seen up to 15cm."

42. My surgical expert advisor, Dr Sanders, advised:

> "There can frequently be limitations in rigid sigmoidoscopy both acutely in terms of bleeding and electively in terms of fecal contamination but, if incomplete, plans should be made to repeat it either when the bleeding has stopped or after a degree of rectal bowel presentation to ensure that distal rectal and anal lesions have not been missed. An alternative to this would be referral on for consideration of a flexible sigmoidoscopy."

43. I accept Dr Sanders' advice. It is concerning that there was a failure to follow up the inconclusive rigid sigmoidoscopy with a repeat investigation or referral for further outpatient investigations.

44. It is apparent that nobody took further action on the inconclusive findings because these findings were not stated clearly in the discharge summary of 12 November. The summary is

inaccurate, as it does not mention the inconclusive nature of the investigation, and implies that the results were normal.

45. I note also that following Mrs A's Haematology Outpatient Clinic appointment on 22 January 2019, Dr G noted in his referral letter to gastroenterology that Mrs A had "had a sigmoidoscopy done which was normal", and that the bleeding appeared to have settled since finishing chemotherapy. This was then relied on, in part, to decline Mrs A's colonoscopy referral.

46. Both expert advisers, Dr Sanders and Dr Jaffurs, have highlighted that there was no documentation to suggest that the rigid sigmoidoscopy was normal, and identified that Dr B obtained less than adequate views on a sigmoidoscopy up to 15cm.

47. I am concerned by the misstatement of the sigmoidoscopy findings in two locations of Mrs A's documentation — the discharge notes on 12 November 2018, and the referral on 22 January 2019. This, alongside other reasons, formed the basis to decline the colonoscopy referral of 22 January. Such misstatement demonstrates the importance of accurate transcription and communication of clinical information, and the effect it can have on the patient journey and the services received.

Failure to refer for colonoscopy or sigmoidoscopy following assessment

48. At each of Mrs A's three presentations to the ED, a rectal examination was undertaken — on each occasion by different doctors. The first examination was undertaken by the surgical registrar, the second by the ED house officer, and the third by the ED registrar. None of these doctors felt any masses on examination. It was only after the third presentation that Mrs A was referred to gastroenterology for consideration of a colonoscopy (although she had been referred for a colonoscopy five days earlier by her haematologist following an outpatient clinic).

49. I will consider each presentation with reference to the specialties providing the care.

<u>ED care</u>

50. With respect to the first and second presentations, where initially care was provided in the Emergency Department, my emergency medicine advisor, Dr William Jaffurs, considered that the care easily met the expected standard, with Mrs A ultimately being assessed by the team of doctors most familiar with her current treatment plans and chemotherapy. Likewise, Dr Jaffurs considered that an appropriate standard of care was met at Mrs A's third ED presentation on 27 January, when she was referred for an outpatient colonoscopy.

51. Nevertheless, Dr Jaffurs advised more generally on the examinations required when a patient presents with rectal bleeding. In the ED setting, the immediate priority is to stabilise the patient. While a history, physical examination, blood testing, and imaging may clarify a diagnosis, Dr Jaffurs commented that this goal is not imperative for the stable patient who can be followed up as an outpatient.

52. Dr Jaffurs did not identify a problem with the rectal examination findings missing a cancer at the limit of the examining finger. The critical decision, in his view, was to request a

colonoscopy or, as an alternative, CT colonoscopy. He stated: "These procedures are requested *regardless of the digital rectal examination, even if it is normal,*" and "the rectal examination, regardless of the result, *does not preclude the need for further investigation of gastrointestinal bleeding*" (my emphasis).

Surgical care

53. My general surgery advisor, Dr Mark Sanders, gave similar advice — that a rectal bleed, whether felt to be spontaneous or not, does need to be investigated, by way of good quality rigid sigmoidoscopy or flexible sigmoidoscopy as a minimum — although such investigations can be deferred until the acute episode has passed.

54. Dr Sanders also commented on the adequacy of the digital rectal examinations, and noted that there were three missed opportunities to identify what he regards as a tumour that was likely palpable (able to be felt) even from the first presentation. I address this issue separately below at paragraph 60.

Haematology care

55. In relation to Mrs A's haematology care (for her relapsing lymphoma), my haematology advisor, Dr Eileen Merriman, advised that the care provided by the haematology team during Mrs A's first presentation (12 November 2018) was appropriate. Dr Merriman highlighted that Dr D correctly noted Mrs A's signs and symptoms, and that Dr D's treatment plan was appropriate. I accept Dr Merriman's advice.

56. When Mrs A presented to the ED a second time on 10 December 2018 (for rectal bleeding), she was transferred to the care of the haematology team, namely consultant haematologist Dr F, and registrar Dr E. Dr E recorded Mrs A's medical history, including the date of her last chemotherapy, and noted that she had experienced rectal bleeding in the previous month. Dr E referred to the rectal examination performed in the ED by Dr C, in which "nil masses" were found, and noted that Mrs A's haemoglobin had fallen to 86g/L from 130g/L the previous week.

57. Dr Merriman advised that it is the role of the haematologist to determine whether a patient's symptoms are the result of an underlying disease (in this case lymphoma) and its treatment, or whether another disease is present that may need further investigation. Dr Merriman said that although Mrs A had a low platelet count (was thrombocytopenic), a haemoglobin fall of 44g/L in one week is concerning. Dr Merriman further advised that while some of the fall in haemoglobin could have been attributed to the effects of chemotherapy, a significant amount of rectal bleeding must have occurred, which would have warranted further investigation at that point. Dr Merriman considers that the haematology team should have discussed a referral for a colonoscopy with the General Surgery or gastroenterology teams, or referred Mrs A for a colonoscopy directly. Dr Merriman noted that no referral was made until six weeks later when Mrs A was seen in the Haematology Outpatient Clinic. Dr Merriman advised that the failure to investigate Mrs A's rectal bleeding further and make a referral for a colonoscopy on 10 December amounted to a moderate departure from accepted practice.

58. That the drop in haemoglobin should have prompted referral for colonoscopy is disputed by Dr F, who submitted that a very significant amount of the haemoglobin decline was due to Mrs A's chemotherapy. Dr F also commented that at that time, Mrs A was too unwell to undergo a procedure. Dr F advised that the plan on discharge was to follow Mrs A closely and to act on any further episodes of bleeding.

59. While acknowledging the clinical context outlined by Dr F, it appears that active referral for investigation of the two bleeds Mrs A had already had was not envisaged unless there was further bleeding. In this respect, the weight of expert advice before me is clear that a potential cause for Mrs A's rectal bleeding should have been investigated, particularly given her repeated presentations, and irrespective of her illness or medications causing a tendency to bleed. That is, investigation of rectal bleeding should, however, still defer to the same investigative pathway in terms of looking for a potential cause, if only to rule things out, and there should have been a referral for colonoscopy/sigmoidoscopy after the first and second presentations regardless of the outcome of the rectal examination.[11] I accept my experts' advice, noting that the source of Mrs A's rectal bleeding was unclear, and further examination/investigation by colonoscopy or sigmoidoscopy was clearly indicated.

Rectal examinations

60. I now comment on the adequacy of the rectal examinations that were undertaken by relatively junior doctors (a house officer and two registrars).

61. As has been identified, Dr Sanders is of the view that the tumour would likely have been able to be felt at each of the three examinations (although it would also have grown in that time). In reaching this view, he analysed the clinical record to determine the tumour's height within the rectum.

62. A number of factors are relevant to the efficacy of a digital rectal examination, including the length of the examiner's finger, pain and discomfort, and the setting in which the examination occurs. For example, examinations in the ED environment are not as ideal as in an elective setting.

63. Dr Jaffurs also commented that a rectal examination can be "uncomfortable and unpleasant for patients, which can limit its usefulness".

64. In the context of three clinicians failing to feel the tumour, I am left wondering whether any of the identified factors had an impact on the effectiveness of those examinations. Without knowing the skill level and personal factors (such as finger length) of the doctors concerned, or what was occurring in the environment at the time of the examinations, I am unable to determine the adequacy of the examinations carried out in this case. What was more important, as has been outlined, was that the "normal" digital rectal examinations did not exclude rectal cancer, and further investigation was warranted.

[11] It is interesting to note that this was in fact done six weeks later on 22 January by Dr G, who, notwithstanding that there had been no further episodes of rectal bleeding, identified that further investigation was necessary.

65. I do emphasise that a rectal examination is a valid investigation. However, adequate emphasis should be placed on its teaching, importance, and limitations, as well as what constitutes a good examination.

Family and medical history

66. On 8 February 2019, Mrs A was seen privately by Dr K, who carried out a rectal examination and made a note of Mrs A's family history of colorectal cancer. However, a family history does not appear to have been taken by any of the clinicians who saw Mrs A during her three acute presentations to the public hospital. Additionally, three of the attending doctors (Dr B, Dr C, and Dr H) did not make a note of Mrs A's change in bowel patterns.

67. Dr Sanders expressed concerns about Dr B's notes, as they do not mention any family history, especially as a first-degree relative of Mrs A had had bowel cancer at a young age. Dr Sanders considers that it would be appropriate for the notes taken to include family history for anyone presenting with rectal bleeding, regardless of the fact that the bleeding is acute and in someone with low platelet numbers. Dr Sanders said that the clinicians should have noted both Mrs A's family history of bowel cancer and her change in bowel patterns.

68. I agree with Dr Sanders' advice, and my concerns extend beyond Dr B, as no other clinicians documented Mrs A's family history. This information would not have been difficult to obtain from Mrs A, and would have informed clinical decision-making.

Colonoscopy referral

69. As outlined above, Mrs A was referred to gastroenterology for a colonoscopy on 22 January 2019. A reply to the colonoscopy referral from gastroenterologist Dr I, dated 25 January 2019, advised that they would not pursue further investigation in an individual who has had two self-limiting episodes of rectal bleeding in the context of a thrombocytopenia that had been resolved at that time, and "a normal sigmoidoscopy". Dr I advised Dr G that there would be an indication for colonoscopy if the patient had "iron deficiency anaemia or had persistent bleeding despite correction of her platelet count". At this time, Mrs A's blood test results showed that her platelets had increased and were within the normal range (platelet count was 170). However, in response to the provisional opinion, Dr I submitted that at the time of the two bleeding episodes, in both November 2018 and December 2018, Mrs A's platelets[12] were well below the normal range.

70. I sought expert advice on the decision to decline referral from a gastroenterologist, Dr Derek Luo. Dr Luo advised that if Mrs A's platelet count was less than 50, her bleeding could be explained by this, and hence declining the referral would not be a departure from the standard of care. If the platelet count was greater than 50, a spontaneous bleed would be less likely and, in this latter situation, Dr I's decision to decline the referral would be a mild departure from the expected standard of care.

[12] Mrs A's platelet count on presentation at the public hospital was 40 in November 2018 and 50 in December 2018. The normal range is between 150–400.

71. Dr I has confirmed that he took into consideration Mrs A's low platelet count at the time of her rectal bleeds (which were both below 50), in the setting of a haemorrhoid that had been identified at the first presentation. He considered the National Access Criteria for colonoscopy, which indicates colonoscopy within six weeks where there is "unexplained rectal bleeding (benign anal causes treated or excluded)" where the patient is older than 50 years. I note that the relevant standards have been set out in Dr Luo's advice at Appendix D.

72. Dr I's rationale for declining the colonoscopy was that a potential benign cause for Mrs A's bleeding had been identified (the haemorrhoid and thrombocytopenia), and therefore she did not meet the access criteria.

73. Taking all this information into consideration, including my expert's advice, I am satisfied that there was no departure from the standard of care relating to the declined referral.

Conclusion

74. SDHB sought its own internal clinical review. SDHB has accepted that it (and its clinicians) failed to identify Mrs A's growing rectal lesion, and that had further investigation been done at the time, either by direct vision or contrast studies, the lesion would have been identified. SDHB attributed the delay in diagnosis to the summative effects of a number of clinical decisions made by a number of different clinicians.

75. I agree, and conclude that there were numerous missed opportunities by a number of SDHB clinicians across several presentations to assess Mrs A's presentation critically and coordinate the appropriate investigations, which had they been performed, would more likely than not have identified Mrs A's rectal cancer.

76. In addition, Mrs A's care was affected negatively by the inaccurate documentation of the sigmoidoscopy results.

77. I consider that the cumulative effect of these factors and missed opportunities demonstrates a clear pattern of poor care, attributable to SDHB as the overall service provider.

78. In summary, I consider that SDHB failed to provide services to Mrs A with reasonable care and skill for the following reasons:

- Following inconclusive rectal examinations at Mrs A's first and second presentations, there was no referral for a colonoscopy or further sigmoidoscopy, or indeed any specific follow-up to identify the cause and source of her bleeding.
- Following Dr B's rigid sigmoidoscopy at Mrs A's first presentation, where views were limited because of the presence of blood, there was no repeat investigation or referral to outpatient services.
- Mrs A's family history of bowel cancer was not explored by any of the clinicians during her three presentations to SDHB.

- Mrs A's sigmoidoscopy results were recorded inaccurately in her discharge summary (from 13 November), which later informed her colonoscopy referral.

79. Taking all these matters into consideration, I find that SDHB breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[13]

Changes made

80. SDHB has advised Mrs A that as a result of concerns around the processes for colonoscopy referrals, the DHB is undertaking a full review of its processes to ensure that referrals for colonoscopy are handled in a more timely and transparent manner.

81. While no deficiencies were identified in the context of this case relating to the declined referral for Mrs A, the issues raised around the access to colonoscopy services at SDHB is a matter of continuing interest to the HDC, and we are actively following up with both the DHB and the Ministry of Health in relation to this.

Recommendations

82. I recommend that SDHB:

a) Provide a face-to-face apology to Mrs A for the breach of the Code identified in this report. Evidence that an apology has been provided is to be sent to HDC within one month of the date of this report.

b) Consider instigating a process where if a patient presents to ED but is an existing patient under the active care of another specialty, that specialty be informed during the presentation or at discharge. SDHB is to report back to HDC on its consideration within two months of the date of this report.

c) Share this case anonymously amongst staff to highlight the importance of:

   i. an adequate rectal examination, including its importance and limitations;

   ii. maintaining accurate patient records that reflect the care provided at each consultation, with full medical and family history notes; and

   iii. critically assessing patients who present on multiple occasions.

d) Encourage opportunities for teaching junior staff on what constitutes a good rectal examination, including its importance and limitations.

[13] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

83. SDHB should report back to HDC on the steps taken to achieve recommendations c) and d) within six months of the date of this report.

Follow-up actions

84. A copy of this report with details identifying the parties removed, except SDHB and the experts who advised on this case, will be sent to Te Aho O Te Kahu — the Cancer Control Agency, the Ministry of Health, the Royal Australasian College of Physicians, the Australasian College for Emergency Medicine, and the Royal Australasian College of Surgeons.

85. A copy of the final report with details identifying the parties removed, except SDHB and the experts who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from Dr William Jaffurs, an emergency medicine specialist:

> "I am responding to your letter of 20 July 2020 requesting expert advice regarding the care given to [Mrs A] in the Emergency Department of [the public hospital] (Southern District Health Board). Thank you for your request to review the above complaint. In doing so I have reviewed the documents sent to me including:
>
> > Your letter, including a timeline of events taken from the clinical records and the GP visit, Surgical referral and colonoscopy report
> >
> > Letter of Complaint from [Mrs A's advocate]
> >
> > Response letter from the Southern District Health Board's [Chief Executive Officer]
> >
> > Pertinent clinical records from [the public hospital] including ED visits, inpatient and clinic notes, GP referral notes and Specialist findings including CT report of the neck/ chest/abdomen and pelvis done 16 January 2019 and MRI of the pelvis done 15 February 2019. A Pathology report is included confirming an adenocarcinoma of the rectum dated 13 February 2019.
>
> I am currently a Fellow of the Australasian College of Emergency Medicine since 1998 and have worked as an Emergency Medicine Specialist at Whangarei Base Hospital since 1997. I was Director of the Emergency Department for my first seven years. I also hold Fellowship with the American College of Emergency Medicine. Having reviewed the persons and entities in this case I can see no conflict of interest on either a personal or professional level. I have read your guidelines for expert advisors.
>
> **Case summary with comments regarding appropriateness of care:**
>
> On 12 November 2018 [Mrs A] presented to the Emergency Department (ED) of [the public hospital]. She was triaged by Nursing staff at 1227 and seen in a timely manner at 1311 by the Haematology Registrar since she was known to the service as having lymphoma and recent chemotherapy. I do not see notes from an Emergency Medicine doctor involved at this visit. She is admitted, found to be anaemic and have low platelets to a level that would allow bleeding. She has transfusions and is seen eventually by the Surgical Registrar who does a rectal exam with 'no masses felt.' [Mrs A] then had sigmoidoscopy to 15 cm which she tolerated well but had 'views limited due to blood in rectum, no active bleeding seen but can not be excluded.' CT scan is considered but the bleeding stops and she is eventually discharged with advice to return if she has further bleeding.
>
> 27 November 2018 [Mrs A] has an arranged admission for chemotherapy. The summary of this visit notes 'No pain, SOB (shortness of breath), nausea bowel issues …'. 10 December 2018 [Mrs A] presents to ED with rectal bleeding at 0443 hours, is triaged at 0525. She appears stable, is not actively bleeding, has appropriate investigations, and is admitted to Haematology with a note and plan at 0900 hours. This note references

communication with an ED doctor who has done a digital rectal examination: 'Empty rectum, nil masses, small amount of dark red clotted blood on glove, no melena.' Her bleeding stops. There is reference to a normal sigmoidoscopy already done which I presume is the one attempted on 12 November's admission. She is eventually discharged without any further procedures and has a CT scan pending to assess her progress with chemotherapy. This is reported towards the end of the files provided done on 21 January 2019 with no abnormality noted in the abdomen or pelvis. I note this was not specifically a CT colonoscopy, but rather a CT done for a different purpose.

27 January 2019 [Mrs A] presents to ED with rectal bleeding at 1530 hours and this time seen by [Dr H], an Emergency Medicine doctor at 1822 hours. She has an Early warning score of 0 suggesting she is stable, no apparent pain or worrisome symptoms other than her recurrence of bleeding. [Dr H's] note is thorough and complete including a rectal exam with 'empty rectum, no blood on finger, no masses or active bleeding.' Her case is discussed with the senior doctor on duty, [Dr J] and a plan is set to refer to Gastroenterology. There is a form from [Dr H] and [Dr J] asking for 'consideration for colonoscopy' dated 27 January 2019 that mentions a previous referral from [Mrs A's] Haematologist, and it is mentioned and actioned in [Dr G's] clinic notes for a visit on 22 January 2019. I see the referral for colonoscopy was declined in a letter dated 25 January 2019 which again refers to a normal sigmoidoscopy done previously at some point.

28 January 2019 [Mrs A] attends [her GP] the day after her ED visit where she is following advice from her Oncologist to seek colonoscopy privately. Her GP repeats the rectal exam and now finds 'tender mucosal irregularity high rectum, suspicious'. She makes the referral based on the history and exam findings.

8 February 2019 [Mrs A] sees the Gastrointestinal Surgeon [Dr K].

13 February 2019 Colonoscopy finds a rectal mass now 4.0 cm from the rectal verge, likely a malignant tumor. This is eventually confirmed by the pathology report.

15 February 2019 MRI of the pelvis shows a 'mid rectal tumor, 8 cm from the rectal verge (4–5 cm on DRE) ...' I presume DRE stands for Digital Rectal exam.

With regard to your specific question: **In particular please comment on the appropriateness of Emergency Medical care provided to [Mrs A] at her presentation on 12 November 2018.**

[Mrs A] was appropriately triaged, seen in a timely manner by nursing staff, and commenced on a path of appropriate investigations and interventions that easily meet the expected standard of care for a New Zealand Emergency Department. As stated above I did not see any direct involvement of the Emergency Medicine doctors, and indeed none was necessary, before seeing the team of doctors who were most familiar with her and her current treatment plans and chemotherapy.

In particular please comment on the appropriateness of Emergency Medical care provided to [Mrs A] at her presentation on 27 January 2019.

Again, [Mrs A] was appropriately triaged as being stable, seen in a timely manner by nursing staff, and commenced on a path of appropriate investigations and interventions. The Emergency Medicine doctor's notes are clear and a chaperoned rectal exam is done. Her Hemoglobin level is 114 (normal range 115–135) and her platelet count is 156 (normal 150–400). [Dr H] discusses the case with his supervising senior doctor, [Dr J]. An appropriate plan for outpatient colonoscopy is formulated and actioned via a referral document. She is stable and therefore not requiring hospital admission, and is given appropriate advice to return if there is further bleeding. In my opinion this sequence and plan is entirely reasonable, avoids an unnecessary admission for [Mrs A], while directing her for a needed colonoscopy. This is how I would expect a similar situation to be handled in a similar Emergency Department and therefore meets the standard of care.

Please comment on the level of skill and experience emergency medicine doctors have in carrying out examinations in patients who present with PR bleeding.

Assessment of patients with rectal bleeding is a common presentation to Emergency Departments. In most cases the internal site of the bleeding is unknown. The initial priority is to stabilize and resuscitate the patient if needed. A history, physical exam, blood testing, and imaging may clarify a specific diagnosis, but this goal is not imperative for a stable patient who may require further investigation or surgery and is available for outpatient follow up. Emergency Medicine doctors are expert at making these decisions. Part of the physical exam involves the digital rectal exam. This was done on several occasions by several doctors, and again I would expect an Emergency Medicine doctor to understand what they are trying to feel. None of the examiners found the mucosal irregularity noted by [Mrs A's] GP, although [Mrs A] had had a rectal exam the day before in ED which may have produced some swelling in the tissue which in retrospect we now know was abnormal. She was well on her way to getting a colonoscopy at that point, regardless of the results of the digital rectal exams.

I do not see a problem with the rectal exam findings missing a cancer at the limit of the examining finger. The critical decision here was to request colonoscopy. Repeated episodes of rectal bleeding require investigation with either colonoscopy, or as an alternative CT colonoscopy which is specific for bowel abnormality and less invasive than conventional colonoscopy. These procedures are requested regardless of the digital rectal exam, even if it is normal, and this was actioned by the Emergency Medicine doctors.

As an academic point, the value and place of the digital rectal exam has been called into question in recent years. The exam is uncomfortable and unpleasant for patients, which can limit its usefulness. Modern imaging techniques including CT and MRI, and the ready availability of timely colonoscopy are ascribed the demise of the essential rectal exam in assessment of many abdominal complaints. Having said this, I consider the rectal exam both occasionally useful and required if possible in the assessment of rectal

bleeding. I have attached an article from The International Journal of Emergency Medicine 2018 11:20 Quinn et al. elaborating on this debate, the unreliability of the rectal exam, and emphasizing that the rectal exam, regardless of the result, does not preclude the need for further investigation of gastrointestinal bleeding.

I am concerned about the possibility of missing Emergency Medicine doctor notes from the 10 December 2018 visit. Reference is made in the admitting Haematology notes that a rectal exam was done and verbally communicated, but a specific notation, even handwritten in the paper notes as a consultation for the rectal exam would be needed to meet the standard of care. I do not have enough information to understand this event or deliver an opinion.

Several of the included documents refer to a 'normal sigmoidoscopy.' I can find no documentation of this. The Surgical Registrar obtained less than adequate views on a sigmoidoscopy to 15 cm and is quite clear about this in the 12 November 2018 note. Therefore there seems to be some confusion that might be resolved with a standard pictograph form that could go in the patient's notes similar to the one used for gastroscopy. Again I do not have enough information to deliver an opinion about the 'normal sigmoidoscopy,' and would defer to my Surgical colleagues.

If I can be of further assistance please contact me.

Sincerely yours,

William Jaffurs,
MD FACEP FACEM
Emergency Medicine Specialist
Whangarei Hospital"

The following further expert advice was obtained from Dr Jaffurs in relation to the ED presentation on 10 December 2018:

"I think the note is complete and appropriate, therefore has no impact on my opinion that ED did their work to the expected standard and that she was referred to her inpatient home team appropriately."

Appendix B: Independent clinical advice to Commissioner

The following expert advice was obtained from Dr Eileen Merriman, a haematologist:

> "Thank you for asking me to provide a report on [Mrs A] … regarding a case of a malignant distal rectal tumour diagnosed in February 2019. My report is based on records sent to me from Southern District Health Board.
>
> I have been provided with copies of: *Letter from Nationwide Health & Disability Advocacy Service 14 November 2019; Timeline taken from excerpts of clinical documentation from 12 Nov 2018–13 Feb 2019; Clinical records from Southern DHB covering the period from 12 Nov 2018–27 Jan 2019.*
>
> I am a consultant haematologist and the Clinical Director and Lead Thrombosis Clinician at North Shore Hospital, Auckland. I graduated from Otago Medical School (Dunedin) in 2001. I have been a fellow of both the Royal Australasian College of Pathologists and the Royal Australasian College of Physicians since 2010. I am the past President and New Zealand councillor for the Thrombosis & Haemostasis Society of Australia and New Zealand (THANZ; 2017–2019). I am fully compliant with ongoing registration and annual college recertification requirements.
>
> [Mrs A], [in her sixties], presented to the Emergency Department at [the public hospital] on 12 November 2018 with PR bleeding. She had a background of relapsed anaplastic large cell lymphoma stage IV, and was being treated with GDP chemotherapy. She was assessed by the haematology registrar ([Dr D]; time 1311) and noted to be day 14 of cycle 4 of chemotherapy. The clinical notes state 'bright red PR bleed in pan' with a 'second small PR bleed in ED ... x2cm clot'. She was noted to have a '2x2 fleshy non-thrombosed haemorrhoid 3 o'clock'. It was also noted that her haemoglobin was 82 g/L with platelets pending and neutrophils 3.8. A PR examination was not performed at that stage. [Dr D] wrote a plan for [Mrs A] to receive tranexamic acid, platelets, 1 unit of red cells and IV fluids.
>
> At 2210, the haematology registrar noted that the Hb had dropped slightly to 80 despite 1 unit of red cells, and that the platelets had increased from 4 x 10^9/L to 45 x 10^9/L after one pool of platelets. [Dr D] also noted that there had been three further PR bleeds since admission, and asked for a surgical review. The general surgical registrar reviewed the patient and performed a rigid sigmoidoscopy, noting the external haemorrhoid but with no masses and blood on the glove or from the anus on withdrawal of the sigmoidoscope. The registrar advised a CT abdomen if [Mrs A] became unstable. [Mrs A] was reviewed on the Haematology ward round the following morning, at which stage it was noted that there had been no further PR bleeding, and [Mrs A] was discharged.
>
> [Mrs A] presented with further PR bleeding on 10/12/18. She was reviewed in the Emergency Department and admitted to the Haematology ward overnight. The haematology notes state that [Mrs A] had passed a 'small amount of blood clots about 4cm length'. The notes also state that a PR examination performed by the ED doctor

found an empty rectum with no masses and a small amount of dark red clotted blood on the glove. The assessment was of 'PR bleeding in the setting of thrombocytopenia'. The full blood count showed a platelet count of 5 x 10^9/L with Hb 86g/L (previously 130g/L the week before). The notes state 'discussed with haematologist; for 2 units of RBC and 1 pool platelets, tranexamic acid tds. Not for surgical review or sigmoidoscopy currently'. [Mrs A] was discharged the following day.

[Mrs A] was reviewed in the Haematology outpatient clinic by [Dr G] on 22/1/2019. [Dr G] noted that [Mrs A] had had two episodes of GI bleeding with thrombocytopenia during chemotherapy and that a sigmoidoscopy had not revealed any abnormalities, and that this appeared to have settled since finishing chemotherapy. However he referred her to gastroenterology for consideration of a colonoscopy. A reply to the referral from [Dr I], gastroenterologist dated 25/1/2019 (typed 31/1/2019) states 'we would not pursue further investigation in an individual who has had two self-limiting episodes of rectal bleeding in the context of a thrombocytopenia, which has now resolved, and a normal sigmoidoscopy', but that 'there would be an indication for colonoscopy if the patient had iron deficiency anaemia or had persistent bleeding despite correction of the platelet count'.

On 27 January 2019, [Mrs A] again presented to the emergency department with PR bleeding. The ED notes state 'PR bleeding approx. 1/52 … stools now red'. A PR exam carried out by the ED doctor is documented as showing 'no fissures, no external haemorrhoids seen, empty rectum, no blood on finger, no masses, no active bleed'. After discussion with ED SMO [Dr J], a referral was sent to gastroenterology and [Mrs A] was discharged home. The following day, [Mrs A] went to her GP who noted minor external haemorrhoids on PR and a tender mucosal irregularity high in the rectum. The GP made an urgent referral to a private gastrointestinal surgeon and endoscopist.

On 13 February 2019, [Mrs A] had a colonoscopy, where she was diagnosed with a malignant tumour in the distal rectum (4cm from the anal verge).

I have been asked to provide an opinion on whether the care provided to [Mrs A] by the Haematology Department at [the public hospital] was reasonable in the circumstances, and why. In particular, I have been asked to address the following points, which I will address in a sequential fashion:

1) *The appropriateness of the haematology team's management of [Mrs A's] PR bleeding presentation on 12 November 2018 including the adequacy of assessments, investigations, diagnoses, plans and coordination with other specialities.*

   The haematology team appropriately noted the thrombocytopenia and anaemia, and transfused red cells and platelets, along with prescribing tranexamic acid. They also appropriately asked for a surgical review, and were advised that a rigid sigmoidoscopy showed an external haemorrhoid but with no masses or blood on the glove or sigmoidoscope on withdrawal from the anus. The surgical registrar had advised a CT abdomen if [Mrs A] became unstable, but in fact her bleeding settled overnight, and I would consider it reasonable to assume that all reasonable steps

had been taken at that time to address the cause of bleeding, especially in the context of a severe chemotherapy-induced thrombocytopenia. My peers would likely be of the same opinion.

2) *The appropriateness of the care provided to [Mrs A] by the haematology team on 10 December 2019 including the adequacy of assessments, investigations, diagnoses, plans and coordination with other teams.*

Although the patient was again thrombocytopenic at this time, a haemoglobin fall of 44g/L in one week is concerning. Although some of the fall in haemoglobin could be attributed to bone marrow suppression due to recent chemotherapy, this would more likely be in the order of no more than 10g/L over one week. I would assume that a significant amount of PR bleeding had occurred, and warranted further investigation at that point with a colonoscopy. However no such referral was made until six weeks later, when [Mrs A] was seen in the haematology outpatient clinic. I consider this to be a moderate departure from standard of care, and believe this would be viewed similarly by my peers. Recommendations for improvement: it would have been good practice to discuss this with the surgical or gastroenterology team and/or refer for colonoscopy at the time of the second presentation with the PR bleed, rather than in a delayed fashion six weeks after the event.

3) *Whether you consider that the haematology department had overall responsibility in the management of [Mrs A's] PR bleeding symptoms.*

The simple answer is yes. With regards to each of the first two presentations, [Mrs A] was admitted under the haematology team with a presenting complaint of PR bleeding. They are therefore primarily responsible for managing this problem. However they did refer to and receive advice from the surgical team during the first admission, and I believe that the haematology team acted appropriately during the first admission based on that advice. My opinion regarding their management during the second admission is as above. With regards to the third presentation, it does not appear that haematology were consulted (at least, there is no documentation of this), and the responsibility for this rests with the Emergency Department at that time, and with the service the Emergency Department doctor consulted (gastroenterology). I believe this would be similarly viewed by my peers. Recommendations for improvement in future would include earlier referral to the gastroenterology service for further investigation. I do note, however that the gastroenterology service turned down the initial referral for colonoscopy in January. The Emergency Department could also have consulted haematology at the time of the third presentation, as haematology had been involved with the first two presentations, and presumably had a better overview of her care at that stage, since [Mrs A] was well known to them.

4) *Any other matters in this case that you consider warrant comment.*

The haematology service is often intimately involved with patients' overall management for months to years due to the complex, chronic nature of the diseases that they treat. In a case such as this, it is the role of the haematologist to determine whether a patient's symptoms are due to the underlying disease (in this case T cell

lymphoma) and its treatment, or whether a concomitant disease process that may need further investigation is present. This is often a complex area and not 'black and white', requiring consultation with other services, as above.

Yours sincerely,

Dr Eileen Merriman
Clinical Director, Clinical Haematologist & Lead Thrombosis Clinician
Dept of Haematology | Waitematā DHB
MBChB BMLSc FRACP FRCPA PhD"

Appendix C: Independent clinical advice to Commissioner

The following expert advice was obtained from general surgeon Dr Mark Sanders:

"I have been requested by the Commissioner to provide an expert opinion on case number C19HDC02143. I have read and agreed to follow the Commissioner's guidelines for independent advisors.

Professional Credentials of 'Expert Advisor' relevant to this report

My name is Mark Nathan Sanders and I am a vocationally registered consultant general surgeon employed by Northland District Health Board.

I hold an MBBS from the University of Newcastle upon Tyne, U.K., awarded in 1988. I hold a fellowship of the Royal College of Surgeons of London, England, and a fellowship of the Royal College of Surgeons of Edinburgh both gained by examination in 1993. I also hold a fellowship of the Royal Australasian College of Surgeons gained by examination in 2001. Following fellowship training I was appointed a consultant senior lecturer at the University of Bristol and the Bristol Royal Infirmary in the U.K. Since 2002 I have worked as a consultant general surgeon based at Whangarei Area Hospital. Since 2007 I have also worked in private practice at Kensington Hospital, Whangarei. My practice in Whangarei encompasses a wide range of general surgical conditions in this provincial hospital setting. I have previously been Head of the Dept of Surgery. I have held various training and committee positions for the Royal Australasian College of Surgeons and I am currently an Examiner for the final fellowship in General Surgery.

CONFLICT OF INTEREST IN THIS CASE

I have no conflicts of interest in this case.

SYNOPSIS OF THE CASE

[Mrs A], hereafter known as the patient, was a patient under the Haematology department at Southern District Health Board with a relapsed anaplastic large cell lymphoma and on salvage chemotherapy, one of the consequences of which had left the patient with a low platelet count, thrombocytopenia. She had presented with bleeding per anus as a new feature for her. This subsequently became a recurrent problem requiring several reviews in hospital and admissions. She had been examined by various doctors including a total of three digital rectal examinations and one rigid sigmoidoscopy with no specific cause found on any of these. The bleeding seemed to settle but then had recurred on several occasions with repeated reviews. The patient was later referred for a colonoscopy, the initial request for which was declined. Subsequently the patient had an examination and review by the GP and, following a referral from that visit, an examination and colonoscopy by a surgeon in the private sector which found a low rectal cancer just above the anorectal ring.

I have specifically been asked to comment on:

1. The appropriateness of the surgical review and plan on 12/11/2018 including:
   a. The adequacy of the findings of the rigid sigmoidoscopy; and
   b. What, if any, further actions should have been taken based on the findings.
2. The appropriateness of the surgical review and plan on 13/11/2018.
3. The levels of skill and experience that general surgical doctors have in carrying out examinations in patients who present with PR bleeding.
4. Any other matters in this case that you consider warrant comment.

EVIDENCE TO SUPPORT CONCLUSION

I have been furnished with information from the Commissioner's office electronically which includes:

1. Letter of complaint dated 14/11/2019
2. A letter of reply from Southern DHB dated 18/12/2019
3. Clinical notes from Southern DHB for timeline covering the period November 2018 to February 2019.

TIMELINE OF EVENTS

I have reviewed the chronology report made up by the HDC office. With the following amendments, I find this to be a correct timeline based on the clinical notes forwarded to me and I will not repeat this detail in my response.

The following amendments that are of relevance should be noted:

1. On page 3 the time from the haematology registrar note should be 10.10pm not 11.10pm.
2. On page 4 the date for the CWR (haematology) by Dr … should read 13/11/2018 at 8.35am not 13th Dec.
3. On page 5 in the top paragraph, 'plan from the surgical team' point 2 should read consideration of repeat sigmoidoscopy to follow if consistently bleeding.
4. There was an arranged admission dated 27/11/2018 with a relevant comment being that no current PR bleeding was encountered. There was also a clinic letter dated 5/12/2018 when again no PR bleeding was mentioned.
5. On page 8 the note from 25/01/2019, a note re. the 'letter from gastroenterology' should also note the next line in this letter which was not included in the HDC chronology report 'there would be an indication for colonoscopy if the patient has iron deficiency, anaemia or persisting bleeding despite correction of platelet count'.

SPECIFIC ISSUES

1. The appropriateness of the surgical review and plan on 12/11/2018.

   In the lead up to the surgical review, on admission, the haematology registrar [Dr D] had commented on a spontaneous bruise on the left forearm which is of note given the low platelet level, therefore giving a tendency to have spontaneous bleeding and 'a large 2x2 fleshy non-thrombosed haemorrhoid at 3 o'clock' but that an internal examination was not undertaken. The patient had low haemoglobin and platelet level and it was later noted that evening that the patient had further PR bleeds with clots despite an increasing level of platelets. Part of the note from the haematology registrar mentions that they would have expected the bleeding should have stopped when the platelets got above 30. This is of relevance in terms of the future investigations of a possible cause as it raises the increased possibility there was some underlying pathology causing this bleeding rather than it just being spontaneous. In any case my feeling is that a PR bleed, whether felt to be spontaneous or not, most likely comes from some underlying pathology and does need to be investigated. However this can be deferred until after the acute episode has passed. The untimed surgical review by [Dr B] was undertaken presumably late at night on 12/11/2018 as the note has been written after the note from [Dr D] at 2210hrs. The history outlines the acute presentation but does not mention any potentially relevant previous or similar episodes, past history, or family history of note (the patient did in fact have a first degree relative with bowel cancer at a young age) or change in the bowel pattern leading up to this. This would be considered appropriate for anyone presenting with PR bleeding regardless of the fact it is acute and in the setting of the thrombocytopenia. Clinical examination documented the external haemorrhoid but specifically mentioned no masses were felt on digital rectal examination although blood was seen on the glove. Rigid sigmoidoscopy was undertaken and comments on the limitation in views secondary to blood. This is a valid reason for potentially missing the visualisation, but not the palpation, of any rectal lesion at this acute time. Comment was made that these 'can not be excluded', although whether this meant bleeding or lesion is difficult to determine from the entry.

   The plan at the end of this to consider a CT angiogram if the patient became unstable and the plan for surgical review the following morning was both quite appropriate given the acute nature of the presentation.

   In retrospect however it is highly likely that the subsequently found rectal cancer was missed on the digital rectal examination although, as mentioned, blood obscuring a view on the rigid sigmoidoscopy may well have limited his direct visualisation by that modality. The rectal cancer was subsequently felt by the GP at the end of January and confirmed in early February the following year but almost certainly the tumour would have been palpable at the time of this review even though it was 3 months until it was formally diagnosed. It should be noted that this was the first of 3 rectal examinations, none of which commented on the mass. The second was documented in the note written at 9.00am on 10/12/19 where a PR (performed by ED doctor) commented on nil masses. The final rectal examination is

documented as being undertaken by ED registrar [Dr H] in the 6.36pm note on 27/01/2019. There were therefore 3 missed opportunities here and, chances are, that the tumour would have grown between each opportunity.

a) In comment to the question regarding adequacy of the findings of the rigid sigmoidoscopy on the review of 12/11/2019 the main issue is the lack of finding the palpable abnormality rather than the rigid sigmoidoscopic findings of blood which is highly likely to have obscured the view of any lesion. This, together with the no documented relevant history for a PR bleed, would constitute a moderate departure from the standard of care practice.

b) What, if any further action should have been taken based on the findings? The acute plan for a CT angiogram and passing on the details to the surgical team the following day was quite appropriate and would have deferred any decision based on this to the follow up team during daylight hours and is appropriate.

2. The appropriateness of the surgical review and plan on 13/11/2018. The consultant team review at 10.00am on 13/11/2018 did include a slightly fuller history. The comment was made of PR bleeding of an unclear source. The plan was for consideration of repeat rigid sigmoidoscopy only if bleeding was on-going and again reiterated the CT angiogram for on-going bleeding. The final point, point 4 in the plan from that notes entry, in the plan states that the 'patients team to inform gastro of bleeds'.

   My feeling would be, as mentioned above, that PR bleeding, even in the presence of thrombocytopenia, should precipitate an investigation to look for a potential underlying cause although this can be done after correction of other parameters and outside the acute setting if that episode self resolves. For this type of fresh PR bleeding that should include a PR and good quality rigid sigmoidoscopy or flexible sigmoidoscopy as a minimum. It is unclear from this plan as to whether point 4 is for consideration of referral to gastroenterology for consideration of further investigation of these bleeds with a flexible scope for example or not. If it was then I would agree this should be quite an appropriate next step.

   This likely being the case means that this slight confusion in documentation would only be a minor deviation in the standard of care.

3. The levels of skill and experience general surgical doctors have in carrying out examinations in patients who present with PR bleeding.

   PR bleeding, both acute and chronic, are standard symptoms which any general surgical doctor should be competent in evaluating. This would include taking history including covering the bleeding itself and any associated symptoms as mentioned above. Basic examination techniques should include a generalised abdominal examination, adequate and accurate digital rectal examination, and after appropriate training, a rigid sigmoidoscopy and proctoscopy. There can frequently be limitations in rigid sigmoidoscopy both acutely in terms of bleeding and electively

in terms of faecal contamination but, if incomplete, plans should be made to repeat either when the bleeding has stopped or after a degree of rectal bowel preparation to ensure that distal rectal and anal lesions have not been missed. An alternative to this would be referral on for consideration of flexible endoscopy.

I think it should be noted that there were three different doctors having undertaken digital rectal examinations, most likely missing what I feel would have been a palpable tumour at each stage.

4. Any other matters in this case that you consider warranting comment.

Regarding the colonoscopy requests, I see the patient was first referred to gastroenterology for consideration of colonoscopy on 22/01/2019. This was declined on 25/01/2019 but that a further internal referral to gastroenterology was made on 27/01/2019 following the further acute presentation with PR bleeding on that day. It is unclear whether this was subsequently acted on as the patient had gone private prior to this. Of note in the decline letter for the colonoscopy was the comment on a normal sigmoidoscopy. It does appear that the patient only had one attempt at a rigid sigmoidoscopy, performed by [Dr B] on 12/11/2018, and this does document that this was limited by blood and therefore could not have been considered normal. Had this been noted it may have been that the patient would have been booked for a colonoscopy.

In patients such as this with other co-morbidities or medications causing a tendency to bleed, investigation of rectal bleeding should however still defer to the same investigative pathway in terms of looking for a potential cause, if only to rule things out. This can be deferred until the acute episode has settled.

Submitted for your review and consideration

Yours sincerely
Mark Sanders MDBS FRCS (Eng) FRCS (Ed) FRACS
Consultant General Surgeon
Northland District Health Board"

The following further advice was obtained from Dr Sanders:

"This report is supplementary to my earlier report and is in response to Southern District Health Board's comments dated 24/09/20.

Specifically this report is in response to the Southern DHB's comments to my (Dr Sanders') report pertaining to:

d) The moderate departure from accepted standards identified for the surgical review carried out by [Dr B] on 12/11/2018.

I maintain that this tumour was likely to be palpable, most likely at the time that all three digital rectal examinations were undertaken. There is no doubt it would have

grown over the time between that initial assessment and eventual diagnosis 20 weeks later and have been expected to have become more readily palpable as time went on but nevertheless still likely to have been palpable at that initial and subsequent digital rectal examinations. Southern DHB's report said that 'it should be noted that at the time of diagnosis the tumour was described as being 4cm from the ano-rectal junction.' The details that I had for completing my report was from the HDC timeline quoting the findings of the private surgeon, [Dr K]. Assuming those details forwarded to me are correct that summary mentions his impression that this tumour was 4cm from the anal verge. The anal verge is the lower/outer end of the anal canal. It is the junction of the anal canal with the skin and not the ano-rectal junction which is the upper end of the anal canal at the level of the pelvic floor levator ani sling and the junction between the upper anal canal and the rectum above. Southern DHB's response talks of the tumour being 4cm above the ano-rectal junction not the anal verge. Using the same measurements that Southern DHB have talked about in their response, if we therefore take the length of the anal canal being between 3–5cm in length it would mean that the tumour was right at the upper end of the anal canal being 4 cm from the anal verge and therefore given the length of the finger that they again describe it would have been readily palpable. I very much suspect that the tumour would have been sizeable enough to have been palpable at the time of the first presentation and obviously would only have increased in size between then and the final diagnosis. If the tumour was truly described as being 4cm from the ano-rectal junction rather than the anal verge then I agree that there may well have been more difficulty in palpating the tumour initially, but from the information I have this does not seem to be the case and I would therefore have expected the tumour to be palpable for the above described reasons and distances.

It is also mentioned in Southern DHB's response to my section of the report that the Emergency Dept assessment of rectal bleeding should just concentrate on this urgent assessment and the acute bleeding problem and not the exploration of 'diagnostic uncertainties'. As I mentioned in my original report, trying to ascertain the likely cause of the bleeding by taking an appropriate history including that of any change in bowel pattern, similar past episodes and any family history of note does remain, even in the acute setting, quite an appropriate set of questions to ask to help determine what the cause of even an acute bleed might be.

Apart from these comments in reply to the response from Southern DHB I have nothing further to add to my original report.

Submitted for your consideration

Yours sincerely

Mark Sanders MDBS FRCS (Eng) FRCS (Ed) FRACS
Consultant General Surgeon
Northland District Health Board"

The following further expert advice was obtained from Dr Sanders:

> "This report is supplementary to my earlier reports on this case and is in response to a request from the HDC for additional clarification particularly with regards to the tumour height and therefore the ability to it being felt on a PR examination.
>
> I have now been forwarded additional notes regarding this case by the HDC and with some additional information requested specifically by myself. These include the now complete clinic letter from [Dr K's] review at his rooms on 8/2/19, the radiology from after the cancer was diagnosed, the final histology from the resection and the operation note from the subsequent resection of the tumour.
>
> The clinic letter from [Dr K's] review at his rooms on 8/2/19 states the tumour was palpable at 5 cm from the anal verge and described as a significant mass involving half the circumference. This finding was 12.5 weeks after the original PR done on 12/11/18, 8.5 weeks after the PR done on 10/12/18 and less than two weeks after the PR done on 27/1/19. The GP's referral letter to [Dr K], 28/1/19, had also talked of a palpable abnormality on PR.
>
> The subsequent colonoscopy on 13/2/19 (done under sedation so examination can be easier) mentions the rectal mass as palpable 4.0cm from the anal verge.
>
> Subsequent MRI, 15/2/19, gives a radiological height (rather than the clinical height) of the tumour 7.6 cm above the anal verge.
>
> The patient subsequently had neo-adjuvant chemo radiotherapy and then a low anterior resection (not APER) with subsequent histology showing distal resection margin >10mm from tumour microscopically and 16mm macroscopically. This would imply the tumour was not involving the anal canal at the time of surgery and the operating surgeon felt they could, and did, get below the tumour. The operation note from that procedure initially states the tumour was palpable at 5cm from the anal verge and easily palpable but that clinically it had shrunk down as a result of the pre-operative chemo-radiotherapy. With the operating surgeons being able to get below the tumour yet still above the anal canal might imply a slightly higher lie of the tumour than right at the upper anal canal however extensive rectal mobilisation was done as part of the surgery and this can lead to being able to get below the tumour. Tumours can shrink down with neo-adjuvant therapy and that was [Dr K's] impression.
>
> It is accepted that a digital PR examination can be difficult and limited in some patients and in some situations leading to difficulty palpating abnormalities. Situations such as those patients with a high BMI, [Mrs A] however had a normal BMI of 23 so was not overweight (details from GP referral letter to [Dr K] in Jan 2019) or anal pain, nil is documented about this being an issue on the PR examinations. Obviously the examiner's finger length is of relevance. Southern DHB's response of 24/9/20 documents this aspect and my reply of 13/11/20 covers the same but, even with the lengths suggested by SDHB as average finger and anal canal lengths digital examination should still have reached at least the lower margin of the tumour. It is also accepted that examination in an emergency department and acute setting can sometimes be more challenging than in a

more elective setting such as a clinic and certainly than when a PR is done as part of a colonoscopy or at operation.

There is therefore some debate over the height above the anal verge of this tumour and therefore its ease of palpation. Some subsequent information forwarded to me does point to this being maybe a little higher, at least at or just above the ano-rectal junction — the MRI findings (although this is a radiological height and we are concerned with a clinical height), the pathology report, (again however we are concerned with clinical rather than pathological heights) and the operation note of being able to get below the tumour while still above the anal canal (again however this was after extensive operative mobilisation of the rectum).

One question is; which described clinical height (i.e. the height palpable on a PR examination) should be taken as the 'true' height and therefore used to assess if this tumour was likely to have been palpable earlier. [Dr K's] description of the tumour being between 4 & 5 cm from anal verge probably has the most weight given that the GP also felt an abnormality. In the notes that I have I can find no evidence verifying Southern DHB's comments, in their reply of 24/9/20, that the tumour was 4 cm above the ano-rectal junction and I think the tumour should be accepted as being 4–5cm above the anal verge (the entrance to the anal canal). Given this it remains likely that the tumour would have been palpable earlier by a good quality PR. It is accepted, as mentioned earlier, that a PR examination in an emergency department setting may not be as ideal an environment as a more elective setting and, if the examiner's finger length was particularly short the tumour may have been at the limit of what might have been palpable, but it remains that there were three opportunities within the 13 week period from initial presentation to diagnosis, for a good quality PR to have felt the tumour. It would have been smaller at initial presentation but highly likely still palpable and more so as time went by. I feel that it therefore remains a moderate departure from the expected standard of care for all three clinicians that undertook the PR examinations.

Recommendations:
As part of the original HDC request advice on recommendations stemming from this case was also requested: Digital rectal examination remains a key, if sometimes overlooked, part of general surgical examination. Adequate emphasis should be placed on its teaching, the importance of an adequate PR exam including what constitutes a good quality exam and the limitations that may be met as well as what pathologies might be encountered.

Submitted for your consideration

Yours sincerely

Mark Sanders MDBS FRCS (Eng) FRCS (Ed) FRACS
Consultant General Surgeon
Northland District Health Board"

Appendix D: Independent clinical advice to Commissioner

The following expert advice was obtained from gastroenterologist Dr Derek Luo:

"My name is Dr Derek Jah-Yuen Luo. I have read and agreed to the guidelines for independent advisors. I have been a Consultant Gastroenterologist in public practice for 11 years and private practice for 10 years. I completed my specialist Gastroenterology training in New Zealand in 2007. I have been instructed by the commissioner to answer the questions shown below to provide an opinion on case number Ref: 19HDC02143.

The sources of information reviewed were sent to me and include

Referral letter to the SDHB Gastroenterology Service, dated 22/1/2019 from [Dr G] Haematologist

Response letter from [Dr I] SDHB Gastroenterology dated 25/1/2019 to [Dr G]

Expert advice requested — please review the enclosed above documentation and advise whether or not you consider the care provided to [Mrs A] by [Dr I] at Southern District Health was reasonable in the circumstances, and why. In particular comment on:

1. What is the usual practice when assessing a referral for a Colonoscopy including what information a clinician ordinarily accesses or considers in making a decision on a referral.

a. What is the standard of care/accepted practice?

I refer to the New Zealand referral criteria for direct access outpatient colonoscopy published by the ministry of health in 2019. I have attached this below to act as a frame-work for basing my responses. These are the criteria a clinician ordinarily accesses or considers in making a decision on a referral. Applying these referral criteria to [Mrs A's] case, she had 2 episodes of PR bleeding during chemotherapy when her platelet count was low (which could be a precipitant). I am uncertain how low this was as the information was not provided to me. A sigmoidoscopy (I am not certain whether this was a rigid or flexible sigmoidoscopy) had presumably excluded anal causes according to [Dr G's] referral. There is no mention of iron deficiency anaemia on the referral letter and I do not have access to the results. With this information in mind, [Mrs A] would likely qualify for a Priority (6 week) direct access colonoscopy. The normal sigmoidoscopy has excluded anal causes. If the degree of thrombocytopenia during chemotherapy was severe eg 50 or below the risk of spontaneous bleeding would be more clinically likely, I would accept that we could keep an eye on this, as this would likely explain her presentation. If there was any doubt, or if there was not enough information, I would arrange for the patient to be seen in clinic.

Two-week category

- Known or suspected CRC (on imaging, or palpable, or visible on rectal examination), for pre-operative procedure to rule out synchronous pathology

- Unexplained rectal bleeding (benign anal causes treated or excluded) with iron deficiency anaemia (haemoglobin below the local reference range)
- Altered bowel habit (looser and/or more frequent) > six weeks' duration plus unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥50 years

Six-week category

- Altered bowel habit (looser and/or more frequent) > six weeks' duration, aged ≥50 years
- Altered bowel habit (looser and/or more frequent) > six weeks' duration plus unexplained rectal bleeding (benign anal causes treated or excluded), aged 40–50 years
- **Unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥50 years** (emphasis added)
- Unexplained iron deficiency anaemia (haemoglobin below local reference range) (see Comments for Services section items 1 and 2)
- New Zealand Guidelines Group (NZGG) Category 2 family history plus one or more of altered bowel habit (looser and/or more frequent) > six weeks' duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥40 years
- NZGG Category 3 family history plus one or more of altered bowel habit (looser and/or more frequent) > six weeks' duration plus unexplained rectal bleeding (benign and anal causes treated or excluded), aged ≥25 years
- Suspected/assessment inflammatory bowel disease (consider FSA)
- Imaging reveals polyp >5 mm

Not accepted

- Acute diarrhoea < six weeks' duration — likely infectious aetiology and self-limited
- Rectal bleeding aged less than 50 years (normal haemoglobin) — consider FSA or flexible sigmoidoscopy if no anal cause
- Irritable bowel syndrome (may require specialist assessment)
- Constipation as a single symptom
- Uncomplicated CT-proven diverticulitis **without** suspicious radiological features
- Abdominal pain alone without any 'six-week category' features
- Decreased ferritin aged <50 years with normal haemoglobin
- Abdominal mass — refer for appropriate imaging

- Metastatic adenocarcinoma unknown primary — 6 percent is due to CRC and in the absence of clinical, radiological, or tumour marker evidence of CRC, colonoscopy is not indicated

'Benign anal causes' is defined as haemorrhoids, anal fissure, anal fistula, inflammatory bowel disease, radiation proctitis and mucosal or full thickness rectal prolapse. If no benign anal cause is identified or bleeding continues after the treatment of these, benign causes can be excluded.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be?

At most, there has been a mild departure if there has been significant thrombocytopenia (platelets <50) then [Dr I] has used his clinical judgement. Given the normal sigmoidoscopy, however, I think a proximal cause needs to be excluded especially if the thrombocytopenia was not significant.

c. How would it be viewed by your peers

My peers would agree with me. Most would recommend a Colonoscopy based on the National referral criteria. They would agree with me that [Dr I] used his clinical judgement and would also query the platelet count as well.

d. Recommendations for improvement that may help prevent a similar occurrence in the future.

This is difficult as [Dr I] has used his clinical judgement and the guidelines help us use a limited resource in a uniform fashion. I would have to give [Dr I] the benefit of the doubt that his clinical impression was to decline this as he felt that there was a clinical explanation for [Mrs A's] presentation.

2. Whether the decision of gastroenterologist, [Dr I] to decline the colonoscopy was appropriate? Please evaluate the appropriateness of the clinical reasons given for declining the referral and the stated advice when a colonoscopy would be indicated.

a. What is the standard of care/accepted practice?

As discussed above, this patient would qualify for a Priority 2 (6 week) colonoscopy based on the national referral criteria as shown above. [Dr I] used his clinical judgement based on the information available to postulate that thrombocytopenia would be the precipitant. This is reasonable, however, it would be important to know what the platelet count was.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, severe) do you consider this to be?

As discussed above. If the platelet count is > 50, this would be a mild departure.

c. How would it be viewed by your peers

As discussed above, we would need to know the platelet count. Clinicians should be able to apply their clinical judgement to guidelines (which are not rules). We would give him the benefit of the doubt that [Dr I] felt that the platelet count was low enough to account for the bleeding.

d. Recommendations for improvement that may help prevent a similar occurrence in the future

No specific recommendations. If [Dr G] was not happy with [Dr I's] decision then a discussion between specialists would seem a reasonable next step."

The following further expert advice was received from Dr Luo:

"If the platelet count was less than 50, then spontaneous bleeding might have occurred as a result of this and hence there would not be a departure from the standard of care. If the platelet was greater than 50, spontaneous bleeding would be less likely and hence there would be a mild departure from the standard of care as this would not explain the bleeding."