Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Health and Disability Commissioner

(Case 20HDC02382)

Introduction

1. This report is the opinion of Morag McDowell, Health and Disability Commissioner.

2. The report discusses the care provided to a man by Southern District Health Board (SDHB) (now Te Whatu Ora Southern).[1]

3. The man had several admissions to Dunedin Hospital for rectal bleeding and underwent a number of investigations, including a colonoscopy [2] and CT colonography (CTC). [3] Subsequently, he was diagnosed with colon cancer.

4. The man and his family made a complaint to this office because of concerns about the delay in the man receiving a colonoscopy despite repeat admissions for rectal bleeding and a family history of bowel cancer. In addition, he was advised over the telephone that his cancer was terminal and that he had a possible life expectancy of 6 to 12 months.

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to SDHB now refer to Te Whatu Ora Southern.
[2] An examination of the inside of the large bowel (the colon, rectum and anus) using a colonoscope (a thin tube-like instrument that contains a light and a lens for viewing the area).
[3] An examination of the inside of the large bowel using a series of X-rays to check for polyps (non-cancerous growths) or cancer.

Names have been removed (except SDHB/Te Whatu Ora Southern, Dunedin Hospital and the advisor) to protect privacy.

5. The following issue was identified for investigation:

- *Whether Southern District Health Board provided the man with an appropriate standard of care between April 2018 to May 2020 (inclusive).*

6. I sought independent advice from a general surgeon, Dr Christoffel Snyman.

Background

7. The man (in his seventies) had a family history of bowel cancer. In 2014 he underwent a colonoscopy and removal of polyps. Between April 2018 and October 2019, he had four admissions to Dunedin Hospital following rectal bleeds. This report focuses primarily on his second admission in August 2019.

April 2018 admission

8. On 25 April 2018, the man was admitted to Dunedin Hospital with rectal bleeding, which settled while he was in hospital. SDHB told HDC that as a result, he was referred for outpatient diagnostic investigation, expected by his clinicians to be colonoscopy. However, when the referral was reviewed (triaged) he was instead referred for a CTC.

9. The man told HDC that the clinician ordered a colonoscopy on this occasion but failed to follow up and make sure it was done or what results were observed.

10. The man underwent a CTC on 5 June 2018. SDHB told HDC that the CTC reported the finding of diverticular disease[4] only. This was consistent with the findings of a colonoscopy performed in 2014. The man told HDC that the only time he was told that he had diverticulosis was when he was admitted to hospital with his first bleed, when he overheard the doctor tell his students why he was there.

11. SDHB told HDC that a CTC is a very good test for examining the colon and is considered to be 'as good' as colonoscopy in diagnosing colon cancer.

Referral for gastroscopy

12. On 21 June 2019, a blood test indicated that the man had low ferritin and s-iron levels consistent with an iron deficiency. He was suffering from upper abdominal (epigastric) pain and was referred to Dunedin Hospital's Gastroenterology Department for a gastroscopy.[5] The referral letter noted that a previous CTC undertaken in June 2018 had revealed diverticulosis, and specifically stated that there was no melaena (black-coloured stool)[6] or haematemesis (vomiting of blood). Rectal bleeding was not noted in the referral letter. An appointment was scheduled for 5 August 2019, but this did not take place because the man was admitted to hospital on 2 August 2019.

[4] Small, bulging pouches in the digestive tract.
[5] A procedure to examine the upper part of the digestive tract (the throat, food pipe (oesophagus) and stomach).
[6] Black-coloured stool may be a result of bleeding in the upper digestive tract.

2 August 2019 admission

13. The man was admitted to Dunedin Hospital with rectal bleeding and required three units of blood. An in-patient gastroscopy (as detailed in his clinical record) indicated no immediate cause for the bleeding. The man told HDC that he cannot recall having a gastroscopy and would have remembered a procedure of this kind.

14. The man was referred for an outpatient colonoscopy. A general surgery consultant at Dunedin Hospital sent two separate referral letters on 8 and 12 August. The colonoscopy was booked for 5 November 2019 (12 weeks and 5 days from the date of the first referral).

Subsequent events

15. Following his 2 August admission, the man had two subsequent instances of rectal bleeding. He was admitted to Dunedin Hospital on 2 and 17 October, but a colonoscopy was not performed, as his outpatient appointment was booked for two weeks' time (on 5 November). Following the 17 October admission, a decision was made to withhold the blood-thinning medication (warfarin) as this may have predisposed him to bleeding.

16. The outpatient colonoscopy on 5 November 2019 showed an ulcerated[7] non-obstructing mass,[8] and a biopsy was taken. The biopsy results indicated that the man had colon cancer.

17. He had surgery on 4 December 2019, and it was found that the cancer had attached to his stomach wall. On discharge, he was prescribed 28 days of Clexane[9] and, in the discharge summary, advice was provided to the man and his GP to 'restart warfarin if no ongoing bleeding'.

18. The man told HDC that in May 2020 he received a telephone call from a nurse, who informed him that his cancer was terminal and indicated that he had between 6 to 12 months to live. This is discussed below.

Guidelines

19. SDHB's 'Indications for Symptomatic Patients & Surveillance of Groups at Increased Risk 71404 V4' criteria and relevant extracts from the Ministry of Health (MoH) 'Referral Criteria for Direct Access Outpatient Colonoscopy or Computed Tomography Colonography 2019'[10] are included at Appendix B.

20. SDHB accepted that in relation to the guidelines in operation at the time, the colonoscopy should have been completed within two weeks, as the man fulfilled the criteria for an urgent colonoscopy. SDHB stated that the possible reason he was scheduled for lower urgency was in reliance on the CTC undertaken in June 2018. SDHB said that as the June 2018 CTC did not

[7] Breaks on the surface of the tissue.
[8] A growth that does not cause blockage.
[9] An anticoagulant.
[10] Ministry of Health. 2019. Referral Criteria for Direct Access Outpatient Colonoscopy or Computed Tomography Colonography. Wellington: Ministry of Health. Available at: https://www.health.govt.nz/system/files/documents/publications/referral-criteria-direct-access-outpatient-colonoscopy-computed-tomography-colonography-feb19-v2.pdf

pick up the lesion, the delay of 'approximately 10 weeks' for the colonoscopy was unfortunate and too long.

Accident Compensation Corporation (ACC) advice

21. As part of the man's treatment injury claim, ACC obtained general surgery advice. In relation to the timeliness of the colonoscopy, the ACC surgeon advised:

> 'Unfortunately, patients do not always fit the exact criteria described in [SDHB's] protocol and it is a matter, therefore, of clinical judgement to consider the four criteria … [T]hese criteria would have reasonably dictated that an urgent colonoscopy should have been performed in April 2018.
>
> A colonoscopy should have been done soon after his April 2018 admission (as was requested by the admitting surgical team).'

Response to provisional opinion

22. The man was provided with an opportunity to comment on the 'information gathered' section of the provisional opinion and these comments have been incorporated throughout the report where relevant.

Southern District Health Board

23. SDHB was provided with an opportunity to comment on the full provisional opinion and had no additional comments and accepted the proposed recommendations.

Opinion: Southern District Health Board — breach

Introduction

24. This report is to be viewed in the context of the following background information.

25. In 2018, SDHB commissioned an external review of issues raised by surgeons in Southland relating to restricted access to colonoscopy services. Following publication of the review in 2019,[11] the DHB commissioned two further reviews of the service in 2020.

26. All three reviews identified that access criteria for colonoscopy services at SDHB were being applied too strictly, with patients being declined for colonoscopies inappropriately.

27. Significant steps were taken by SDHB to remedy the situation, as noted below at paragraphs 51–52.

25 April 2018 admission — no breach

28. As outlined previously, the man received an outpatient CTC following his 25 April hospital admission, which identified no sinister cause for his rectal bleeding. The ACC expert advice concluded that the man should have received an urgent colonoscopy (as originally requested by his admitting surgical team).

[11] Review report available at: https://www.southernhealth.nz/sites/default/files/2019-07/SDHB%20Endoscopy%20Cases%20Report%20Final%20-%20redacted.pdf.

29. My independent advisor, general and colorectal surgeon Dr Christoffel Snyman, advised that the reasons for changing this investigation to a CTC were reasonable and appropriate. He said that a CTC is a recognised alternative to colonoscopy for the detection of colorectal cancer. He noted that CTC is considered to have comparative detection rates for lesions greater than 10mm, including cancers, and it is endorsed as a suitable test by both the MoH and the Bowel Cancer NZ group. He advised that a solitary episode of rectal bleeding and a CTC showing diverticulosis only, would not require further follow-up or investigations.

30. I acknowledge that the report from ACC was critical of SDHB for not undertaking a colonoscopy on this occasion. However, I accept Dr Snyman's advice that a CTC was a reasonable alternative to colonoscopy. In doing so I also note that the clinical rationale for the CTC was to prevent the cessation of the man's warfarin (which would have been required with the colonoscopy option), and the prior clear colonoscopy in 2014. I am therefore not critical of this decision.

Gastroscopy referral — no breach

31. Prior to the man's admission on 2 August 2019, blood test results indicated that he had an iron deficiency. He was also suffering from epigastric pain and was referred by his GP for an outpatient gastroscopy at Dunedin Hospital's Gastroenterology Department.

32. Dr Snyman advised that this referral would not have triggered a colonoscopy at SDHB, as the man had had a good quality CTC a year previously, and he had not reported rectal bleeding to his GP at this stage. Dr Snyman considered that SDHB's actions in relation to this referral were acceptable.

Delayed colonoscopy — breach

33. The man required three units of blood during his 2 August 2019 admission, due to his rectal bleeding. He was discharged after the bleeding had settled, with an outpatient colonoscopy booked for 5 November 2019 (12 weeks and 5 days following the first referral letter dated 8 August 2019). Dr Snyman advised that the man's presentation on this occasion did not meet the criteria for an acute CTC as per the SDHB criteria, as the bleeding had settled in hospital. Dr Snyman agreed with the decision for an outpatient colonoscopy.

34. However, Dr Snyman advised that as per both the SDHB and MoH colonoscopy referral criteria, the man fulfilled the criteria for an urgent outpatient colonoscopy at this time. Dr Snyman considered that the colonoscopy should have been completed within two weeks. While SDHB acknowledged that the colonoscopy should have been completed within two weeks, it explained that the possible reason for the lower urgency was reliance on the earlier normal CTC from June 2018. On reflection of this response, Dr Snyman considered this to be a reasonable explanation, but advised that the request could have been prioritised under the six-week category instead.

35. In any event, the man's colonoscopy wait time exceeded SDHB's own recommended timeframe and the MoH's guidelines by at least six weeks. Dr Snyman considered this delay to be a moderate deviation from the accepted standard of care.

36. I accept Dr Snyman's advice. While I acknowledge Dr Snyman's comment that it is unlikely that an earlier colonoscopy would have altered the outcome, ultimately the delay in diagnosing the man's cancer led to a delay in commencing treatment. For failing to provide the man with a colonoscopy in accordance with the timeframes in SDHB's and MoH's referral criteria guidelines, I find that SDHB breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[12]

37. I am, of course, aware of the pressure faced by colonoscopy services at a national level due to an increase in demand paired with workforce shortages and recruitment challenges. Fundamentally, however, it is my view that when investigations are clinically indicated as urgent or semi-urgent, healthcare consumers have the right to expect such investigations to be scheduled sooner than occurred in this case. That such delays are common does not excuse the delays, and I am concerned that if a culture of tolerance of unacceptable delays develops across localities, this will become normalised and patients will be put at risk. The passage of time between seeing a patient and scheduling a colonoscopy does not support good clinical decision-making, and timely colonoscopy access is a critical systems issue. A timely diagnosis can be particularly important for reducing morbidity and mortality for cancer patients, and often it is a key factor in survivability. Long waits for diagnostic procedures can also have a significant psychological impact on patients and their whānau, who may be concerned that they have cancer.

38. I note that since the review commissioned by SDHB in 2018, significant work has been done to improve the access to colonoscopy services. This is outlined below.

Anticoagulant advice — adverse comment

39. Following his surgery on 4 December 2019, the man was discharged with advice to restart warfarin if there was no bleeding, and he was given a 28-day supply of Clexane. Both medications are blood thinners (anticoagulants), which pre-dispose the patient to bleeding.

40. Dr Snyman advised that the combination of Clexane and warfarin would not normally be prescribed, as the risk of bleeding is high. He further commented that usually warfarin is re-started following the completion of Clexane. He noted that the discharge advice could have been much clearer in respect of the anticoagulants and that it is important to take any ambiguity out of anticoagulation management when people are prescribed Clexane following major surgery. He also said that it should not be the role of primary care to manage anticoagulation, noting that plans for management are best developed when specialist expertise is available.

41. I agree and add that nor should the consumer have to try to understand discharge advice that lacks clarity. I consider that Te Whatu Ora Southern should both reflect on Dr Snyman's clinical advice about the concurrent use of anticoagulant medication and provide clearer discharge advice about anticoagulation. I will make a recommendation to this effect.

[12] Every consumer has the right to have services provided with reasonable care and skill.

Communication — other comment

42. The man told HDC that in May 2020 he received a telephone call from a nurse informing him that his cancer was terminal and that he had between 6 to 12 months to live.

43. SDHB told HDC that in May 2020 the man had a CT PET,[13] and that this is probably the first time it was clear that the disease was no longer able to be cured. SDHB stated that after a CT PET scan, usually the patient expects to be contacted with the results. The hospital has specialist cancer nurses who speak with patients, help to co-ordinate tests and treatment, and review patients when they come to the hospital (the nurses are involved in the whole process of care). SDHB told HDC that it is likely that the person who rang the man knew him well and had been involved in his care both before and after the telephone call. SDHB noted that the call occurred during the COVID-19 pandemic when the hospital was in lockdown, and there were strict instructions that most patients could not be brought into the hospital.

44. A clinical nurse specialist telephoned the man on 24 May 2020, and there is very clear documentation of the call in the clinic letter related to the call. The call was made in the presence of the man's wife.

45. SDHB told HDC that understandably, the man and his wife found the call distressing, and SDHB apologised that they did not feel that sufficient support was given. SDHB said that normally, this sort of information is delivered in person, but it occurred in this way to reduce the number of patients attending hospital because of the risk of COVID-19.

46. I acknowledge that receiving a terminal diagnosis over the telephone is not what one would expect, but in the unique and unprecedented circumstances of the pandemic I accept SDHB's response that there were limited options for providing this distressing but important information.

Family history — other comment

47. The man had a family history of bowel cancer. He told HDC that when he discussed this with SDHB, he was told that there was no mention of this history in his records. The man was concerned that SDHB did not have a complete family history detailing his heightened risk of bowel cancer.

48. In contrast, SDHB told HDC that the man's reported family history of bowel cancer is documented in numerous places in his records, including the last referral for colonoscopy, GP referral letters, and previous colonoscopy reports. SDHB stated that the team looking after the man requested the appropriate tests for someone with a family history of colorectal cancer. The records provided to HDC confirm this.

49. SDHB noted that the family history meant that he would have been eligible for a screening colonoscopy on a routine basis, but the fact that he had symptoms increased the urgency for investigation to semi-urgent. The man received a colonoscopy within four months of his GP referral.

[13] A scan used to diagnose a variety of diseases, including cancer.

50. I accept SDHB's response that it was cognisant of the man's family history when making clinical decisions. As such, I am not critical of SDHB for its handling of the family history in this respect.

Changes made since events

51. In October 2021 MoH advised HDC that SDHB had taken significant actions to improve and respond to the historical issues regarding access to colonoscopy services. The DHB streamlined referral acceptance processes, increased clinical capacity, and reviewed acute bowel cancer presentations. MoH further stated that these measures mean that the service being delivered now meets all the standards outlined by the National Bowel Screening Programme.

52. HDC has been in active discussions with Te Whatu Ora Southern and the Ministry of Health regarding the actions taken following the external reviews of the district's colonoscopy services. On assessment of the information provided to me, I am satisfied that Te Whatu Ora Southern has shown a commitment to implementing the recommendations of the reviews, and many of the issues identified have been addressed. I will continue to take a close interest in the quality of this service and will maintain a watching brief over the pattern of complaints in this area.

Recommendations

53. I recommend that Te Whatu Ora Southern:

a) Provide the man and his family with a written apology for the deficiency in the care provided. The apology is to be sent to HDC within three weeks of the date of this report, for sending to the man.

b) Consider a standardised checklist and format for the provision of anticoagulation advice on discharge, to ensure that all relevant aspects of advice are covered and presented in a manner that can be readily understood by the patient. Te Whatu Ora is to report back to HDC with the outcome of its consideration within three months of the date of this report.

c) Provide HDC with an update on current wait times for colonoscopy services, including any actions being taken to address delays where wait times are outside expected timeframes.

Follow-up action

54. A copy of this report with details identifying the parties removed, except SDHB/Te Whatu Ora Southern, Dunedin Hospital, and the advisor on this case, will be sent to Te Whatu Ora|Health New Zealand and Te Aho o Te Kahu|Cancer Control Agency and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Dr Christoffel Snyman:

'REF: C20HDC02382

Complaint: [Patient]/Southern District Health Board (SDHB)

I have been asked by the HDC to provide an opinion to the Commissioner on case number C20HDC02382.

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My name is Christoffel Gerhardus Snyman. I qualified as a Fellow of the Australasian College of Surgeons (FRACS) in 2003. I am a full-time consultant general surgeon and CMO in a public hospital.

Endoscopy is a major part of my practice.

I do not have a personal or professional conflict in this case.

Expert advice requested

Please review the enclosed documentation and advise whether you consider the care provided to [the man] by Southern DHB was reasonable in the circumstances and why.

As previously noted, we are specifically seeking comment on whether appropriate priority was given for investigation (assessment/referrals) of [the man's] condition on the various occasions when he presented with rectal bleeding, and whether this was actioned in line with the relevant policies and Ministry of Health Guidelines.

Please advise:

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

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

c. How would it be viewed by your peers?

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

Documents provided

- Copy of referral of complaint from the Nationwide Health and Disability Advocacy Service dated 21 December 2020.
- Southern District Health Board's response dated 29 March 2021.
- Clinical records, including scan images, from Southern DHB covering the period in question.

- Relevant Southern DHB policies.

Additional Resource

- MOH guidelines — Referral Criteria for Direct Access Outpatient Colonoscopy or Computed Tomography Colonography 2019.

Summary

[The man] is concerned that there was a significant delay in the diagnosis of his terminal bowel cancer. He has a family history of colorectal cancer and a personal history of polyps and rectal bleeds, and considers that a colonoscopy referral should have been expedited sooner when he began experiencing symptoms.

Summary of Questions

- April 2018 Admission.
  - No deviation from standard of care.
- August 2019 Admission.
  - Moderate deviation from standard of care.
- October 2019 Admission.
  - No deviation from standard of care.

Discussion

April 2018 Admission

No deviation from standard of care.

[The man] was admitted with rectal bleeding to SDHB 25 April 2018. He was appropriately managed as an in-patient for his bleeding.

He was referred for an outpatient colonoscopy upon discharge.

SDHB state in their reply that this was changed to a CT colonography (CTC). The reasons as given by SDHB were reasonable and appropriate.

CTC is a recognised alternative to colonoscopy for the detection of CRCa. It is considered to have a comparative detection rate for lesions > 10mm including cancers. It is endorsed as a suitable test by both the MOH and the Bowel Cancer NZ group.

[The man] fitted within the 6-week time frame criteria based on 'Unexplained rectal bleeding (benign anal causes treated)' as per SDHB criteria, Appendix A.

[The man] fitted within the 6-week category as per MOH guidelines 'Unexplained rectal bleeding (benign anal causes treated or excluded) aged > 50 years'.

The CTC was done on 05 June 2018. This was within 6 weeks (42 days) of referral. This time frame fits with the MOH referral criteria and SDHB's own referral criteria as per Appendix A.

The CTC showed diverticulosis and no other cause for concern. No further follow-up was done.

There is no deviation from standard of care.

I have no doubt that all my colleagues would agree that a solitary episode of PR bleeding and a CTC showing diverticulosis only would not require further follow-up or investigations.

Based on [the man's] family history and his rectal bleeding, he fulfils the 6 week criteria for colonoscopy or CTC as per SDHB criteria, Appendix A, as well as the MOH guidelines.

August 2019 Admission

Moderate deviation from standard of care.

Prior to his acute admission, [the man] was referred for a gastroscopy based on epigastric pain and iron deficiency anaemia. The referral letter from the GP (02/07/2019) specifically states there is no melena or hematemesis. There is no mention of PR bleeding.

The attached blood results to this referral shows iron deficiency (S-iron low, Ferritin low) and a Normocytic hypochromic anaemia (low haemoglobin, normal MCV, low MCH).

This referral from the GP will not have triggered a colonoscopy. [The man] had a good quality CTC a year previously and did not report PR bleeding to his GP at this stage. A referral for gastroscopy only was accepted subsequent to this referral and was appropriate.

[The man] was admitted with PR bleeding on 02 August 2019.

[The man] required 3 units of blood during this admission. This did not meet the SDHB criteria for 'Acute colonoscopy or CTC' as per SDHB Appendix A.

The gastroscopy was appropriately done as an in-patient. It was normal.

He was booked for an outpatient colonoscopy.

As [the man's] bleeding settled in hospital, I agree with the decision for an outpatient colonoscopy.

Upon discharge, [the man] did fulfil the criteria for an urgent colonoscopy as per both SDHB and MOH guideline referral criteria: 'Unexplained rectal bleeding with iron deficiency anaemia'.

Under these criteria, the colonoscopy should have been done within 2 weeks.

[The man] was booked for a colonoscopy that was scheduled for 5 November 2019.

The relevance of anaemia at his stage can be debated as [the man] had just had overt rectal bleeding requiring transfusion. [The man's] anaemia did therefore not strictly fit into the definition at this stage. As [the man] had anaemia on his referral for gastroscopy, I consider it appropriate to include the anaemia in the indications for colonoscopy.

[The man] received his colonoscopy on 05 November 2019, just over 10 weeks later.

SDHB states in their reply that the time frame may reflect the false reassurance they felt from the normal CTC in June 2018.

I find the explanation from SDHB reasonable and will accept that as a result of the CTC, the request may have been prioritised under the 6-week category.

If the colonoscopy was done within 6 weeks, I would've considered this to be a minor (to no) deviation from standard of care.

The procedure waiting time frame exceeded SDHB's own recommendations and that of the MOH guidelines by more than 4 weeks. I consider this to be a moderate deviation from standard of care.

A major deviation would be if no colonoscopy had been booked at all.

The same comment as above (point 11) relates to the relevance of [the man's] family history during this admission.

October 2019 Admission

No deviation from standard of care.

[The man] was admitted with 2 further episodes of PR bleeding. During this admission it settled upon withholding Warfarin. No blood transfusion was required.

[The man] did not fulfil the criteria for an acute colonoscopy during this admission as per SDHB guidelines, Appendix A.

His booked colonoscopy was only 2 weeks away. It was reasonable to leave it at that without expediting it. Unless it was done as an in-patient, any attempt at expediting this time frame would have changed the date by a few days at most.

[The man] received a Colonoscopy 2 weeks later.

There is no deviation from standard of care relating to this admission.

It is generally accepted across NZ to book colonoscopies as elective procedures if at all possible as it is practical.

General Comment

Whilst SDHB may have deviated from their colonoscopy prioritisation times, it is unlikely that an earlier colonoscopy following [the man's] August admission would have altered his oncological outcome.

[The man] was admitted electively for a laparoscopic right hemicolectomy on 04 December 2019 and discharged on 08 December 2019. There is clear documentation throughout his admission. There is a clear documentation of discharge criteria met. My only criticism relates to the discharge summary advice on anti-coagulation management.

The advice to GP and patient is to restart Warfarin if no bleeding.

[The man] was going to take Clexane for 28 days. We do not usually prescribe combined Clexane and Warfarin as the risk of bleeding is high. Usually Warfarin is restarted following completion of Clexane.

This could have been specified much clearer on discharge. Compare to the discharge summary on 21 October 2019 in which the Warfarin management plan was excellent.

I consider this to be lazy discharge practice. SDHB could consider a standardised discharge advice to take any ambiguity out of the anticoagulation management when patients are prescribed prophylactic Clexane following major surgery.

I personally consider it an abrogation of duty when we give vague anticoagulation discharge advice for primary care to sort out. It would be silly to expect primary care to manage anticoagulation, if a good plan can't be formulated when surrounded by all the specialists and expertise to consult on the matter.

Gerrie Snyman'

The following subsequent advice was received from Dr Snyman:

'REF: C20HDC02382

Complaint: [Patient]/Southern District Health Board (SDHB)

I have been asked by the HDC to provide further comment on case number C20HDC02382 in relation to Te Whatu Ora Health New Zealand Southern's reply.

I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My name is Christoffel Gerhardus Snyman. I qualified as a Fellow of the Australasian College of Surgeons (FRACS) in 2003. I am a full time consultant general surgeon and CMO in a public hospital.

Endoscopy is a major part of my practice.

I do not have a personal or professional conflict in this case.

Expert advice requested

Any further comments based on my review of the additional documents and replies.

Documents provided (as a single document package)

Te Whatu Ora Health New Zealand Southern reply 26 July 2022

Dr … report 18 July 2022

Genetic service letter 25 January 2022

Provision of Care Event documents 19 July 2022

Colonoscopy diagnostic waiting time indicator tables 2019 (July–September)

Colonoscopy report 05/11/2019

Upper GI Bleeding (Otago) document 20/10/2021

ACC document pages 03–08 and 17–20 of 422

Comment

I take note of all the documents and have reviewed them. I take note of the various opinions and comments.

I restrict my reply to only the comments that require a reply relating to my report.

Dr … *comment on my opinion of moderate deviation from standard of care*

I refer to my original report points 20–29. I believe it sets out adequately my reasoning for why I consider the deviation to be moderate; I have no further addition.

I take note of Dr … reference to the waiting times across New Zealand and the general lack of meeting these "standards".

I have sympathy for his reasoning, however that reasoning falls in my opinion into a different conversation of resource. I can only comment on a service as measured against our national guidelines and waiting time criteria after considering mitigating factors.

My comments and opinions remain unchanged as stated in my original report.

Gerrie Snyman'

Appendix B: Standards

The Ministry of Health 'Referral Criteria for Direct Access Outpatient Colonoscopy or Computed Tomography Colonography 2019'[1] referral criteria for the two-week category includes:

> 'Unexplained rectal bleeding (benign anal causes treated or excluded) with iron deficiency anaemia (haemoglobin below the local reference range).'

The six-week category includes the following criteria:

> 'Unexplained rectal bleeding (benign anal causes treated or excluded) aged ≥50 years
>
> Unexplained iron deficiency anaemia (haemoglobin below local reference range)
>
> 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'

SDHB's Indications for Symptomatic Patients & Surveillance of Groups at Increased Risk 71404 V4 referral criteria for the two-week category includes:

> 'unexplained rectal bleeding with iron deficiency anaemia (benign anal causes treated — haemoglobin below local reference range)'

The six-week category includes the following criteria:

> 'Unexplained rectal bleeding (benign anal causes treated) — if > age 50
>
> Iron deficiency anaemia — for women < 55 menstruation history should be obtained
>
> NZGG (New Zealand Guidelines Group) Cat. 2 plus one or more of altered bowel habit AND rectal bleeding (more frequent and/or looser stools; benign anal causes excluded) — if age >40
>
> NZGG Cat. 3 plus one or more of altered bowel habit AND rectal bleeding (more frequent and/or looser stools; benign anal causes excluded) — if age >25 years'

[1] Ministry of Health. 2019. Referral Criteria for Direct Access Outpatient Colonoscopy or Computed Tomography Colonography. Wellington: Ministry of Health. Published February 2019. Available at: https://www.health.govt.nz/system/files/documents/publications/referral-criteria-direct-access-outpatient-colonoscopy-computed-tomography-colonography-feb19-v2.pdf.