Health New Zealand | Te Whatu Ora Waikato
General and Colorectal Surgeon, Dr B
General and Colorectal Surgeon, Dr C

A Report by the
Deputy Health and Disability Commissioner

(20HDC01217)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman who was experiencing ongoing rectal bleeding and altered bowel habits.

2. At the time of events, the woman was aged in her fifties and had a family history of colorectal cancer. In 2015, a colonoscopy found no abnormal results. The woman began to experience blood in her stool from September 2017 and was referred to the Gastroenterology Department at Waikato Hospital (Health New Zealand|Te Whatu Ora (Health NZ) Waikato) in early November 2017. A general and colorectal surgeon performed a flexible sigmoidoscopy, which was reported as normal. In January 2018, the woman was referred back to the general and colorectal surgeon with ongoing rectal bleeding. In May 2018, the woman was reviewed by a second general and colorectal surgeon, who did not perform a digital rectal examination (DRE) and proctoscopy/sigmoidoscopy. The woman was referred for another colonoscopy but was advised that the expected wait time would be 120 days (four months). In the meantime, the woman underwent a colonoscopy with a private provider, and, sadly, she was advised that she had a malignant lesion (cancer).

Findings

3. The second general and colorectal surgeon was found to have breached Right 4(1) of the Code for failing to conduct a physical examination in May 2018, and for not documenting his reasons for not doing so.

4. The Deputy Commissioner found Health NZ in breach of Right 4(2) of the Code for failing to adhere to the Ministry of Health guidelines, in that it advised the woman that she was likely to wait 120 days for a colonoscopy, when the guidelines at the time stated that all colonoscopies of the woman's priority were to be completed within 42 days.

5. The first general and colorectal surgeon was criticised for discharging the woman back to her general practitioner in November 2017, after the results of the sigmoidoscopy did not identify a cause for her ongoing rectal bleeding.

Recommendations

6. The Deputy Commissioner recommended that Health NZ Waikato provide a formal apology to the woman, develop guidelines around the expectations of timeframes for sending clinic correspondence, and conduct an audit of colonoscopy referrals between January 2023 and January 2024 to identify whether colonoscopies were completed within Ministry of Health guidelines.

7. It was recommended that the second general and colorectal surgeon provide a formal apology to the woman and undertake an audit of clinical appointments for investigation of rectal bleeding, to ensure that appropriate physical examinations have occurred and have been documented.

Names have been removed (except Health NZ|Te Whatu Ora Waikato, Waikato Hospital, Thames Hospital, and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

8. It was recommended that should the first general and colorectal surgeon return to practice, he review the 'Standards for individuals performing national bowel screening colonoscopy in New Zealand' and consider incorporating the recommendations related to informed consent, and that he provide HDC with a written reflection on the findings in this report.

Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided to his wife, Mrs A, by Dr B at Waikato District Health Board (Health NZ Waikato).[1] The following issues were identified for investigation:

- *Whether Dr B provided Mrs A with an appropriate standard of care in 2017 and 2018.*
- *Whether Dr C provided Mrs A with an appropriate standard of care in May and June 2018.*
- *Whether Waikato District Health Board provided Mrs A with an appropriate standard of care in 2017 and 2018.*

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

11. The parties directly involved in the investigation were:

Mrs A	Consumer
Health NZ Waikato	Group provider
Dr B	Consultant general and colorectal surgeon
Dr C	Consultant general and colorectal surgeon

12. Further information was received from ACC.

13. ACC advisor gastroenterologist Dr D is also mentioned in this report.

14. Independent clinical advice was obtained from Dr Gerry Snyman, a general surgeon (Appendix A).

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards and established Health New Zealand|Te Whatu Ora in their place.

Information gathered during investigation

Introduction

15. Mrs A (aged in her fifties at the time of events) had a family history of colorectal cancer. In 2015, following altered bowel habits, she had a colonoscopy,[2] which found no abnormal results. Mrs A began to experience blood in her stool from approximately September 2017 and was referred to the Gastroenterology Department at Waikato Hospital (Health NZ Waikato) in early November 2017. On 27 November 2017, Dr B, a consultant general and colorectal surgeon, performed a flexible sigmoidoscopy[3] at Thames Hospital, which was reported as normal.

16. On 8 January 2018, Mrs A was referred to Dr B again due to ongoing rectal bleeding. However, because of the recent normal sigmoidoscopy, Dr B passed the referral to the General Surgery Department at Waikato Hospital.

17. On 9 May 2018, Mrs A was reviewed by general and colorectal surgeon Dr C, who documented that Mrs A had ongoing bleeding and passing of mucus. He referred her back to Thames Hospital for a further colonoscopy. Mrs A was advised that the expected wait-time for the colonoscopy would be 120 days (four months). In the meantime (on 12 June 2018), Mrs A underwent a colonoscopy with a private provider. Unfortunately, the results of the colonoscopy showed a malignant lesion[4] approximately 4cm from the anal verge.[5] The cancer was resected in November 2018, but, sadly, in June 2019 she was advised that the cancer had metastasised[6] to her lungs.

Summary of events

2017

18. On 29 September 2017, Mrs A visited her GP as she had sustained an injury. Mrs A said that she thought she had seen blood in her stool, so her GP ordered a faecal occult blood (FOB) test.[7] The result was positive (ie, blood was detected in the stool) and her faecal calprotectin[8] was mildly raised but her bloods were normal. Following receipt of the positive FOB test (on 3 November 2017), Mrs A's GP referred Mrs A to the Gastroenterology Department at Waikato Hospital for review. The referral was prioritised as Priority 2, to be seen within six weeks.

19. On 27 November 2017, Mrs A underwent a flexible sigmoidoscopy performed by Dr B at Thames Hospital. The findings showed that the 'entire examined colon appeared normal' and that 10 random biopsies were taken, which also returned normal results. The

[2] Examination of the inside of the large intestine, including the colon, rectum, and anus.
[3] An examination of the lower third of the large intestine.
[4] A cancerous tumour. A subsequent MRI confirmed a 3.7cm long lesion.
[5] Where the anal canal connects to the outside skin at the anus.
[6] Spread.
[7] A test to check stool samples for hidden (occult) blood.
[8] A test to check for inflammation in the bowel.

'recommendation' was for Mrs A to continue her current medications, and she was discharged back to the care of her GP.

2018

January

20. On 8 January 2018, Mrs A attended a further appointment with her GP because of increased bleeding.[9] Mrs A's GP conducted a physical examination, the results of which were normal, but she did not undertake an extensive rectal examination as she was reassured by the normal sigmoidoscopy in November 2017. Accordingly, Mrs A was referred back to the Gastroenterology Department at Waikato Hospital that day, as 'no explanation for the ongoing bleeding' could be found. The referral stated that Mrs A had been experiencing bleeding daily, and that a recent sigmoidoscopy and biopsies had been normal. The referral also stated that Mrs A had undergone a normal colonoscopy in 2015, and that no haemorrhoids or other cause for the bleeding had been identified. Mrs A's family history of cancer was also listed on the referral form.

21. Health NZ told HDC that the referral was reviewed and referred to Thames Hospital on 14 January 'to be under the care of [Dr B] as [Mrs A] was known to this clinician'. In a letter for the purpose of responding to ACC, Dr B stated:

> 'This patient had an absolute normal complete colonoscopy on 27.08.2015 and another normal flexible sigmoidoscopy on 27.11.2017. If she really has ongoing PR bleedings she probably requires a review by the Gastroenterology [Department]. (small bowel investigation?).'

22. Dr B told HDC that on 15 January, the referral was sent back to Waikato Hospital General Surgery Triage. On 17 January, Waikato Hospital triage forwarded the referral to the colorectal team. The referral was accepted on 23 January and triaged as category 4 (routine — usually to be seen within 5–6 months). Health NZ told HDC that the decision to triage the referral as 'routine' was likely based on the recent normal flexible sigmoidoscopy findings.

May

23. On 9 May 2018, Mrs A was reviewed by general and colorectal surgeon Dr C at Waikato Hospital. The clinic letter to Mrs A's GP (approved and signed on 27 June 2018) stated that Mrs A's symptoms (of passing blood and mucus) had worsened over recent months (since her previous flexible sigmoidoscopy) and that Mrs A 'is worried that there is significant pathology in her bowels that we have not found'. Dr C wrote:

> 'I think it is worth re-colonoscoping her for a better view and we will do multiple biopsies from the terminal ileum down and if she has any haemorrhoids … or signs of excess mucosa or mucosal prolapse then these will be banded at the same time. She

[9] The clinical notes record that Mrs A was experiencing '[m]ucousy [bright red] blood on [the] outside of [her] stool' every morning and that it was more blood than previously. The clinical notes also document that Mrs A was experiencing normal daily soft stool; that she had some urgency with abdominal pain prior to defaecation; that she had no abdominal pain; and that her weight was stable.

> would like to have her procedure done in Thames Hospital and I have referred her on for this.'

24. Regarding the examinations undertaken during the appointment, Dr C told HDC that for patients experiencing rectal bleeding, his usual practice is to undertake a rectal examination and a sigmoidoscopy. However, there is no documentation of any discussion about the need for a physical examination, and the clinic letter contains no reference to Dr C having conducted a physical examination. Dr C accepted that he should have conducted a physical examination and cannot recall with certainty why he did not do so.

25. Dr C said that the decision not to perform a rectal examination and/or sigmoidoscopy was likely influenced by the 'possible diagnosis of inflammatory bowel disease ([per rectum] bleeding and mucus and previous histological findings of inflammations', that there were no masses found in recent colonoscopy and flexible sigmoidoscopy performed in November 2017', as well as the normal colonoscopy three years previously. Dr C said that he was likely reassured that no further rectal examination was required immediately because it had taken place during the above procedures. Dr C told HDC:

> 'Rectal examinations are usually performed at the time of endoscopies and therefore at the time I would no doubt have been reassured (albeit with hindsight falsely reassuring) by the above examinations being normal … I have spent some time reflecting on [Mrs A's] case and with the benefit of hindsight I regret not performing a rectal examination and sigmoidoscopy. While the factors outlined above clearly influenced my decision, I have no hesitation in apologizing to [Mrs A] for my role [in delaying] her diagnosis and treatment.'

26. Mrs A told HDC that a student nurse asked if she would give her consent for Dr C to examine her and told her that she '[might] need an operation later'. Mrs A said that this was not explained to her well, and she declined. She told HDC: 'Had [Dr C] explained to me the importance of an exam, there and then, I would [have] been 6 + weeks ahead in finding my large cancer tumor, and treatment for it.' In response to this, Dr C advised that he does not recall having a student nurse present during the consultation, and his role, both at the time and now, 'does not include teaching or supervising student nurses'. Dr C stated: 'I therefore think it would be unlikely I would have a student nurse present with me during my consultation with [Mrs A].' In response to the provisional opinion, Mrs A clarified that a student nurse came into the room with a registered nurse prior to her consultation with Dr C and before he was present in the room. She said that later, Dr C entered the room by himself and conducted the consultation.

27. Dr C wrote a clinic letter to Dr B at Thames Hospital (typed on 22 June 2018 — 44 days after the clinic appointment), which stated: 'I would appreciate it if you could see [Mrs A] and re-colonoscope her again. Please see my clinic letter to the GP.' This letter was approved and signed by Dr C on 27 June 2018. The letter to Mrs A's GP (referred to above) was approved and signed on 27 June 2018.

28. Dr C told HDC that as the agreed plan was for Mrs A to undergo a repeat colonoscopy, he sent a request using the 'internal request form' to Thames Hospital dated 9 May 2018. Health NZ Waikato told HDC that in 2018 it had a paper-based referral system, and it has been unable to locate a physical copy of the form. However, it provided a screenshot of its electronic system, which confirmed that a referral was made on 9 May 2018 for a repeat colonoscopy. The screenshot shows that the referral was given a priority of 3 (should be seen within 42 days). Dr C said that given Mrs A's symptoms, his usual practice would have been to prioritise her for an urgent colonoscopy. He said that usually, referrals are sent with a category of urgency, and these are then re-prioritised. Dr C stated that he could not comment on whether this was the case with Mrs A's referral, but he said: 'It would have been a significant deviation from my normal practices not to request an urgent colonoscopy in this situation.' However, Health NZ Waikato told HDC that it does not re-prioritise endoscopy referrals made by senior medical officer (SMO) endoscopists. (Dr C is an SMO endoscopist.)

29. Health NZ Waikato told HDC that when a patient referral is received in the endoscopy suite, a booking clerk will upload the information from the paper form to the electronic system and 'waitlist' the patient referral. The priority of the referral is then entered using a drop-down box.

30. In relation to the delay in approving the clinic letters, Dr C told HDC:

> 'Unknown to me at the time, there was a delay in sending my dictated referral letter to Thames Hospital. I cannot now recall why my dictated referral letter was not signed at an earlier time. The only explanation that I could … think of, [is that] I was away on leave either annual, conferences or both but I am not certain of this.'

Diagnosis

31. While waiting for the further colonoscopy at Thames Hospital, Mrs A arranged to undergo a private colonoscopy on 12 June 2018. The findings showed a large ulcerated rectal mass approximately 4cm from the anal verge that was 'likely malignant'. Further investigations showed that Mrs A had rectal cancer. At the time of making the complaint, Mrs A advised that the cancer had spread to her lungs.

Further information

Dr B

32. Dr B told HDC:

> 'I accept that I did not identify [Mrs A's] rectal cancer during her colonoscopy procedure in 2017. As I have said in my ACC response, I am very sorry that I have not seen the rectal cancer despite thorough clinical and endoscopic examination. I am devastated learning about the consequences that this has caused. Please accept my sincere apology.'

33. Dr B has not been practising since 2019.

ACC

34. ACC sought expert clinical advice from gastroenterologist Dr D, for the purpose of assessing a treatment injury claim. The advice focused on whether Mrs A's diagnosis of cancer could have been made earlier.

35. Dr D considered that a 'competently-performed rigid sigmoidoscopy would almost certainly have identified the cancer'. He advised that the most likely reason for the flexible sigmoidoscopy not identifying the lesion was suboptimal examination by the endoscopist (in this case, Dr B). Dr D advised:

> 'Pictures supplied from the flexible sigmoidoscopy do not adequately demonstrate that the rectum was completely visualised — only one picture was taken and it is likely to be distal to the position of the cancer as measured on the MRI, or of the opposite wall. The alternate explanation that the rectal cancer grew extremely quickly from a non-visible lesion to a 4cm mass in only 7 months is extremely unlikely both through the very low chance that a colorectal tumour can grow that fast, and the fact that the symptoms of rectal bleeding were present prior to the flexible sigmoidoscopy and continued and worsened until the cancer was discovered — the bleeding was almost certainly due to the presence of a cancer or advanced polyp that was there the entire time.'

36. In relation to the further investigations, Dr D stated:

> 'I believe flexible sigmoidoscopy was a perfectly appropriate investigation of the symptoms of rectal bleeding. In terms of further investigations after the non-identification of the bleeding source in November 2017, I note that [Mrs A's] GP re-referred to Waikato DHB for ongoing rectal bleeding symptoms in January 2018. Triaging of this referral was understandably coloured by the reported normal flexible sigmoidoscopy of 6 weeks earlier, and [Mrs A] ended up waiting approximately 4 months for a clinic review. I note that neither rigid sigmoidoscopy [n]or even rectal exam with a glove were performed at this time, and likely the former and possibly the latter would have identified the cancer at this point if they had been done. There was a further 5 week delay until eventual diagnosis on 12 June, although this is only a minority of the total 28 week delay.'

Responses to provisional opinion

37. Mrs A was given an opportunity to comment on the 'information gathered' section of the provisional report. Where relevant, her comments have been incorporated into this report.

38. Health NZ Waikato, Dr C, and Dr B were also given the opportunity to comment on relevant sections of the provisional opinion.

Health NZ Waikato

39. Health NZ Waikato accepted the findings and recommendations made in the provisional opinion.

Dr C

40. Dr C told HDC:

> 'As set out in my previous response to Dr Snyman's clinical advice, there were several factors that likely influenced my decision [not to conduct a physical examination and proctoscopy/sigmoidoscopy and not to document the reasons for this]. However, I can see that I should have examined [Mrs A] that day (if she consented). I should have documented my reasons for not conducting the examination. I have no hesitation in apologising for these deficiencies in the care I provided to [Mrs A] and undertaking an audit of clinic appointments for investigation of rectal bleeding to ensure that appropriate physical examinations have occurred and have been documented.'

41. Dr C said that his documentation in this case is not reflective of his usual standards of practice. He stated:

> '[Mrs A's] case and this HDC process has however, been a useful illustration and reminder of the importance of thorough documentation and to not deviate from my usual standard of care, even when I am reassured by prior examinations and previously normal results, where it may be appropriate, to document my rationale if I deviate from my usual practice.'

Dr B

42. Dr B had no further comment to make in response to the provisional opinion.

Relevant standards

43. Health NZ Waikato provided HDC with a copy of the 'Ministry of Health Diagnostic Waiting Time Indicator, Colonoscopy', which were the guidelines in place and relevant to the Waikato district in 2017.

44. The Waiting Time Indicator stipulates the following expected wait-times:

- Urgent: 90% of people accepted for an urgent diagnostic colonoscopy receive (or are waiting for) their procedure within 14 calendar days or less, and 100% within 30 days or less.
- Non-urgent: 70% of people accepted for a non-urgent diagnostic colonoscopy will receive (or are waiting for) their procedure within 42 calendar days or less and 100% within 90 days or less.
- Surveillance: 70% of people waiting for a surveillance colonoscopy receive (or are waiting for) their procedure within 84 calendar days or less of the planned date and 100% within 120 days or less.

- Bowel screening: 95% of participants who returned a positive FOB test have a first offered diagnostic date that is within 45 working days of their FOB test result being recorded in the national bowel screening programme (NBSP) IT system.

Opinion: Introduction

45. As part of my assessment of this complaint, I sought independent clinical advice from general surgeon Dr Gerrie Snyman. Dr Snyman prefaced his advice with the following:

> 'The review must acknowledge that in any diagnostic process a significant diagnosis may be delayed or missed. This may not be a reflection of negligence or failure, it may be that, despite best care and intention, a significant diagnosis was missed or delayed. My review is to evaluate if [Mrs A] was provided every appropriate opportunity to have her cancer diagnosed earlier.'

46. I agree with Dr Snyman's advice in this regard. Notwithstanding the devastating outcome for Mrs A, it is the role of this Office to assess whether the care provided to Mrs A at the time of the events, and with the information available to the clinicians at the time, was appropriate in the circumstances.

Opinion: Dr C — breach

47. Mrs A was reviewed by general and colorectal surgeon Dr C on 9 May 2018. The referral from her GP (initially sent to Waikato Hospital and then redirected to Thames Hospital by Dr B) noted that Mrs A had been experiencing recurrent rectal bleeding with mucus and that she had undergone investigations in 2015 and 2017 that returned normal results. The referral also stated that no explanation for the bleeding had been identified.

48. Despite Dr C advising HDC that his usual practice (for patients experiencing rectal bleeding) is to conduct a physical examination and sigmoidoscopy, he did not conduct either examination during his consultation with Mrs A.

49. I note that there are two different versions of events explaining why a physical examination was not done. Mrs A's account is that she was offered a physical examination by a student nurse (who was accompanied by a registered nurse) prior to her consultation with Dr C, but it was not explained to her well, so she declined. Dr C's recollection is that he was likely influenced by the possible diagnosis of inflammatory bowel disease and that Mrs A's previous results (colonoscopy and sigmoidoscopy) had been normal. Dr C advised that it was highly unlikely that a student nurse was present during his consultation with Mrs A. Mrs A agreed that the conversation occurred before Dr C entered the consultation room. In the

absence of any contemporaneous clinical documentation of a discussion about the requirement for a physical examination, I am unable to make a finding on whether this occurred prior to Dr C's consultation with Mrs A. In any event, both versions of events resulted in Mrs A not receiving a physical examination or sigmoidoscopy.

50. Dr Snyman advised:

> 'At the time of clinic review [Mrs A] had rectal bleeding for more than 6 months. Colonic and rectal causes had already been excluded by the flexible sigmoidoscopy. The anal canal remained to be evaluated as a probable cause. It can only be done by DRE [digital rectal examination] and proctoscopy … The referral criteria for colonoscopy in similar circumstances would be persistent rectal bleeding with anal causes excluded. Whether the likely cause was thought to be from anal pathology or possibly from more proximal in the colon, a DRE and proctoscopy was a necessity to diagnose or exclude anal pathology.'

51. I note that although Dr C did not conduct a physical examination or proctoscopy/ sigmoidoscopy, he did refer Mrs A for a colonoscopy. In any event, Dr Snyman advised that the failure to conduct a physical examination and proctoscopy/sigmoidoscopy on this occasion represented a moderate departure from accepted standards. However, Dr Snyman advised that this deviation from accepted standards would have been considered 'minor to none' if Dr C had referred the colonoscopy as urgent, to be done within 14 days. Dr Snyman stated: 'It would be reasonable to defer a DRE and proctoscopy in these circumstances to the endoscopy event as it is expected to happen urgently.'

52. I have considered the evidence concerning the prioritisation of the colonoscopy referral. Dr C said that his usual practice was to prioritise such referrals as urgent, but the referral may have been reprioritised. Health NZ Waikato told HDC that referrals are not reprioritised if the referral is made by an SMO. As Dr C was an SMO, it is unlikely that the referral was reprioritised. However, Health NZ Waikato also advised that when the paper referral is received in the endoscopy suite, it is loaded on to the system by a booking clerk, who will select the priority from a 'drop-down box'. This means there is a possibility that the paper referral was entered into the system as priority 3 as a result of human error. Owing to the time that has lapsed and because the paper referral cannot be located, I am unable to make a finding on whether or not Dr C prioritised the referral as urgent.

53. I am concerned that despite Mrs A's ongoing rectal bleeding with no known cause, Dr C did not conduct a physical examination or sigmoidoscopy as per his usual practice. I acknowledge Dr Snyman's advice that he would consider the departure 'minor to none' if Dr C did order an urgent colonoscopy. As noted above, I have been unable to make a finding on this matter. However, Dr C's reasoning for not conducting a physical examination was not because he had ordered an urgent colonoscopy and expected a physical examination to take place during that procedure. Further, I am concerned that Dr C did not document his reasons for not undertaking a physical examination, particularly as conducting one was his usual practice.

54. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) provides that every consumer has the right to have services provided with reasonable care and skill. As discussed above, I consider Dr C's rationale for not conducting a physical examination to be insufficient in the circumstances, and I am concerned that he did not document the reasons for not undertaking a physical examination, particularly as this comprises part of his usual practice.

55. In my view, these failures were significant, as Mrs A's colonoscopy was prioritised (whether in error, or by Dr C) as priority 3 (non-urgent) and she did not receive a physical examination to aid the investigation of her recurrent bleeding. Accordingly, I consider that Dr C failed to provide Mrs A with an appropriate standard of care and breached Right 4(1) of the Code.

Opinion: Health New Zealand | Te Whatu Ora Waikato — breach

Wait-time — breach

56. The 'Ministry of Health Diagnostic Waiting Time Indicator, Colonoscopy' was the guideline in place at the time of the events in the Waikato district relating to appropriate wait-times for colonoscopies. The Waiting Time Indicator states that 95% of patients who have returned a positive FOB test result will have a first offered diagnostic date that is within 45 working days of their FOB test result being recorded in the NBSP IT system, and 100% of patients will have a first offered diagnostic date that is within 90 working days.

57. On 3 November 2017, Mrs A's GP referred Mrs A to the Waikato Hospital Gastroenterology Department for review, as she had been experiencing blood in her stool and a FOB test had come back positive. On 27 November 2017, Mrs A underwent a diagnostic flexible sigmoidoscopy.

58. My independent advisor, Dr Snyman, advised that the time from first referral to diagnostic procedure was appropriate, as it sat within the referral criteria for direct access outpatient colonoscopy.

59. On 8 January 2018, Mrs A was referred back to Waikato Hospital (by her GP) because of persistent rectal bleeding. Mrs A's referral was accepted as Priority 4 (routine, to be seen within four months) on 23 January 2018. Subsequently she was seen for a clinic appointment on 9 May 2018 by general and colorectal surgeon Dr C. Dr Snyman advised that this was within the Ministry of Health guidelines for all patients to be seen within four months of receiving a referral.

60. As an outcome of the clinic review on 9 May 2018, Mrs A was referred for a colonoscopy. She was sent confirmation of the colonoscopy booking and was advised that it was expected to be completed within four months (120 days).

61. Although it is unclear whether the referral was initially prioritised as urgent and mistakenly entered onto the electronic system as priority 3 (or whether the referral was incorrectly prioritised by Dr C), the referral was prioritised as priority 3 — to be done within 42 days.

62. In relation to this wait-time, Dr Snyman advised:

> 'This was not a surveillance colonoscopy. The [Ministry of Health] KPI indicated that 70% of non-urgent colonoscopies are to be done within 42 days. 4 Months (120 days) for [Mrs A's] colonoscopy would be well outside the recommended waiting times.'

63. I also note that according to the Waiting Time Indicator, 100% of patients waiting for a non-urgent colonoscopy must be seen within 90 days.

64. Dr Snyman advised:

> '[Health NZ Waikato] did not offer a colonoscopy to be available within this timeframe but within a timeframe of 120 days. This was well outside [Ministry of Health] guidelines. I would consider this to be a moderate deviation from standard of care. As this timeline was never tested it is speculation as to when the colonoscopy may have occurred, however the upfront time breach indicator of 120 days is sufficient for me to feel that this is a moderate departure … as it signals that [Health NZ Waikato] was not even endeavoring to adhere to the 90 days absolute boundary.'

65. I agree. I am concerned that Health NZ Waikato failed to adhere to relevant Ministry of Health guidelines, in that it advised Mrs A that she was likely to wait 120 days (four months) to receive the colonoscopy. Irrespective of who prioritised the referral, a priority 3 referral should mean a wait time of 42 days. Mrs A subsequently underwent the colonoscopy privately, meaning that she did not 'wait' 120 days. However, as Dr Snyman has advised, 'it signals that [Health NZ Waikato] was not even endeavoring to adhere to the 90 days absolute boundary'.

66. Right 4(2) of the Code stipulates that every consumer has the right to have services provided that comply with relevant standards. In my view, Health NZ Waikato failed to adhere to the Ministry of Health guidelines in that it advised Mrs A that she was likely to wait 120 days for a colonoscopy, despite the guidelines at that time stating that all colonoscopies of that priority were to be completed within 42 days. Accordingly, I find that Health NZ Waikato breached Right 4(2) of the Code.

67. I note that Dr Snyman advised that all other referrals were actioned within the Ministry of Health timeframes.

Clinic correspondence — adverse comment

68. Following the consultation, Dr C wrote a clinic letter to Dr B at Thames Hospital (typed on 22 June 2018), which advised that Dr B should repeat Mrs A's colonoscopy. The letter was approved and signed by Dr C on 27 June 2018. He said that as the agreed plan was for Mrs A to undergo a repeat colonoscopy at Thames Hospital, he sent a request using the 'internal

request form' to Thames Hospital dated 9 May 2018. Subsequently, a letter confirming Mrs A's referral for a colonoscopy was dated 21 May 2018.

69. In relation to the delay in sending the clinic letters (from the consultation on 9 May to the date of the letters being signed on 27 June), Dr C told HDC:

> 'Unknown to me at the time, there was a delay in sending my dictated referral letter to Thames Hospital. I cannot now recall why my dictated referral letter was not signed at an earlier time. The only explanation that I could … think of, [is that] I was away on leave either annual, conferences or both but I am not certain of this.'

70. Dr Snyman advised that there are no national guidelines around clinic correspondence timeframes, but at his organisation there is an expectation that all letters will be typed and signed within seven days of a clinic appointment. If not, reminders are sent, and an escalation pathway is followed.

71. Dr Snyman considered that whilst the clinic correspondence was unreasonably delayed, the referral for a colonoscopy was sent with 'appropriate expedience'. He advised that the delay in sending the clinic correspondence constituted a minor departure from an appropriate standard of care. However, he also advised that '[t]he deviation would have been major had it directly influenced timely care being provided'. Dr Snyman considered this departure to reflect a system deficiency, not a personal deficiency by Dr C.

72. In summary, Dr Snyman advised:

> 'It is worth reflecting on the downstream effect such delays in correspondence may have on patient care. Delays in getting our clinic assessments and subsequent plans to GPs and colleagues presents what may be valuable information from being available to be taken into consideration when planning further care. Reflect on the official referral letter being approved after [Mrs A] had already had the colonoscopy in private.'

73. I agree. In my view, this issue is attributable to the system, because there was also a delay in the medical typists typing the letter, and Dr C indicated that he may have been on leave during this time.

74. I accept that in these circumstances, the delay in sending the clinic letter is somewhat mitigated by the fact that the referral was sent by Dr C within an appropriate timeframe (9 May — the day of the clinic appointment). However, when several clinicians are involved in the care of a patient, it is crucial that important information is sent between clinicians in a timely manner to ensure continuity of care. I encourage Health NZ Waikato to reflect on my comments and those of Dr Snyman.

Opinion: Dr B — adverse comment

Adequacy of flexible sigmoidoscopy — educational comment

75. On 27 November 2017, Dr B performed a flexible sigmoidoscopy on Mrs A as part of an investigation into her ongoing rectal bleeding. The findings showed that the 'entire examined colon appeared normal' and that 10 random biopsies were taken, which also returned normal results.

76. Dr Snyman advised that from his review of the sigmoidoscopy, 'a standard adequate endoscopy was performed that meets the key performance indicators'. He said that it is reasonable, however, to state that the rectal cancer or mucosal abnormality was probably present at the time of the sigmoidoscopy but was missed, as it is unlikely that an interval cancer developed in the subsequent six months. In any event, Dr Snyman advised:

> 'International studies indicate that endoscopists miss significant pathology in 4% of cases. Whilst this figure includes a range of pathology, it also includes cancers. This figure reflects the miss rate of pathology despite best care and best practice application and is a reflection of the limitations of the investigation as a combination of equipment, the test itself, the operator and the colon as an organ. It is not reflective of negligence. For all these reasons, I find no deviation from standard of care as it relates to the performance of a flexible sigmoidoscopy on [Mrs A] by [Dr B].'

77. I acknowledge Dr D's comments that the imaging may not have been optimal, and I accept that it may be that the tumour was present but not visualised on 27 November 2017. I note that Dr Snyman and Dr D both agree that it is likely that the abnormality was present at the time of the scan. However, as the abnormality was not present on the imaging taken at the time, this is not a matter I am now able to determine.

78. I note that Dr Snyman's advice contrasts with that of Dr D's, and that Dr D's advice is more critical of the care provided to Mrs A by Dr B. However, advice is sought by ACC to assess whether a treatment injury caused an outcome for a patient, or whether a delay in treatment occurred as a result. Conversely, advice is provided to HDC to measure the care that was provided against appropriate standards. Accordingly, based on the evidence I have reviewed, and taking into account that there was no abnormality present on the imaging taken, I am not critical of the care provided by Dr B. However, this case is an important reminder of the importance of accurate imaging.

Discharge back to GP — adverse comment

79. Following the flexible sigmoidoscopy on 27 November 2017, and the subsequent normal results, Dr B discharged Mrs A back to her GP with the 'recommendation' being to continue her current medications.

80. Mrs A was referred to Dr B for further investigation of rectal bleeding and other symptoms. However, the sigmoidoscopy found no explanation for the bleeding, and no recommendation was made for further investigation into the cause of the bleeding.

81. Dr Snyman advised that it was unreasonable for Mrs A to be discharged back to the care of her GP after the sigmoidoscopy failed to identify a clear cause for the bleeding. He advised that if the bleeding had stopped at the time of the sigmoidoscopy, it would have been reasonable for Dr B to refer Mrs A back to her GP for future review and management as appropriate. However, as Mrs A was referred back to Waikato Hospital with persistent bleeding within six weeks of the sigmoidoscopy, it is reasonable to assume that the bleeding at the time of the endoscopy was ongoing. Dr Snyman advised:

> '[Mrs A] should have had a proctoscopy as a more accurate method of evaluating presumed anal pathology as a cause of her bleeding after excluding a cause in the rectum and distal colon. Whether this proctoscopy should have been done as part of the flexible sigmoidoscopy can be debated. I personally feel that the proctoscopy should have been done on the day after the endoscopy did not show a cause. It is to be noted that [Mrs A] was referred for flexible sigmoidoscopy and hemorrhoid management if needed [by her GP]. At the very least, [Mrs A] should have been referred at this stage for further review of her rectal bleeding and or investigations at a surgical clinic.'

82. Dr Snyman advised that Mrs A should have been booked for a complete colonoscopy to look for other causes 'in the more proximal colon'. However, neither of these further investigations (proctoscopy or colonoscopy) were recommended by Dr B, nor did they occur.

83. Dr Snyman considered that the lack of safety-netting represented a minor deviation from an accepted standard of care. He advised that this is because it is common practice to discharge patients back to primary care following exclusion of major pathology, and the sigmoidoscopy (without the benefit of hindsight) had done so. Dr Snyman advised: 'The deviation does not relate to nor reflect the missed pathology as later diagnosed, but a missed opportunity to provide better care for a problem that had not been solved yet.'

84. Dr Snyman stated:

> 'It is worth reflecting that had a proctoscopy been done as part of the endoscopy evaluation, it may have showed the cancer. It may also have failed to show any significant pathology. In the latter it may have provided an opportunity to review rectal bleeding for which no cause had been established. This may have led on to further investigations that may have altered the diagnostic timeline. I appreciate the "maybes", however, the lack of excluding anal pathology in a timely fashion certainly denied any of the maybes from becoming a definite.'

85. In light of Mrs A's ongoing bleeding, Dr B should have referred her for further testing, such as a proctoscopy or colonoscopy. In my view, this was a missed opportunity to identify the cause of Mrs A's persistent bleeding, and I am critical that Dr B referred Mrs A back to the care of her GP without offering further testing or investigations.

86. It is my role to assess whether, with the information available to Mrs A's healthcare providers at the time of events, those providers acted appropriately and in accordance with relevant standards. When retrospectively assessing the care provided, it is important that I

make that assessment free from hindsight bias, notwithstanding the serious outcome for Mrs A. Accordingly, my criticisms above are limited to Dr B's decision to discharge Mrs A back to her GP following the sigmoidoscopy, and I encourage Dr B to reflect on Dr Snyman's comments in this regard.

Recommendations

87. I recommend that Dr C:

a) Provide a written apology to Mrs A for the failings identified in this case. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Mrs A.

b) Arrange an audit of 30 clinic appointments for investigation of rectal bleeding, to ensure that appropriate physical examinations have occurred and have been documented. If the audit identifies any deficiencies, Dr C is to advise what steps he has taken to improve his practice in this respect. The results of the audit, and any changes made, are to be provided to HDC within six months of the date of this report.

88. I recommend that should Dr B return to practice, he:

a) Review the 'Standards for individuals performing national bowel screening colonoscopy in New Zealand' and consider incorporating the recommendations under standard 3d on informed consent as a preformat part of endoscopy consent. Dr B is to report back to HDC with a reflection on this review, within three months of the date of his return to practice.

b) Reflect on the findings in this report that relate to him and provide a written reflection to HDC, within three months of the date of his return to practice.

89. I recommend that Health NZ Waikato:

a) Provide a written apology to Mrs A for the failings identified in this case. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Mrs A.

b) Develop guidelines, and reinforce them with clinicians, around the expectation of timeframes for sending clinic correspondence. These guidelines should include information about how correspondence should be managed if the responsible clinician is on extended leave. Evidence of the development and implementation of these guidelines is to be sent to HDC for review within six months of the date of this report.

c) Conduct an audit of colonoscopy referrals between January 2023 and January 2024, to identify whether the colonoscopies were completed within Ministry of Health

guidelines. Health NZ Waikato is to report back on the results of this audit and its plan to address any deficiencies, within six months of the date of this report.

Follow-up actions

90. A copy of this report with details identifying the parties removed, except Waikato Hospital, Thames Hospital, Health NZ|Te Whatu Ora Waikato, and the independent advisor on this case, will be sent to the Medical Council of New Zealand, and it will be advised of the names of Dr C and Dr B.

91. A copy of this report with details identifying the parties removed, except Waikato Hospital, Thames Hospital, Health NZ|Te Whatu Ora Waikato, and the independent advisor on this case, will be sent to 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 Gerrie Snyman:

'**REF: 20HDC01217**

Complaint: [Dr B]/[Dr C]/Waikato District Health Board

I have been asked by the Health and Disability Commissioner to provide an opinion to the Commissioner on case number **20HDC01217**.

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 Chief Medical Officer in a public hospital. The management of rectal bleeding and endoscopy is 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 [Mrs A] by [Dr B] and [Dr C] at WDHB was reasonable in the circumstances, and why.

In particular, please comment on:

WDHB

1. The timeliness of care provided to [Mrs A] and appropriateness of any waiting times.
2. Whether there were any unnecessary delays in care or treatment.
3. Any issues concerning management of referrals between departments, including referrals between the General Surgery departments at Waikato Hospital and Thames Hospital, and the Gastroenterology department.
4. The adequacy of WDHB's policies and procedures.
5. Any other comments you may wish to make on the systems in place and the care provided to [Mrs A] as it relates to the failure to diagnose rectal cancer.

[Dr B] (Thames Hospital)

1. The standard of care provided to [Mrs A] in relation to the procedure performed on 27 November 2017.
2. Whether any further review, investigation or tests should have been undertaken when [Mrs A] was referred back to WDHB by her GP in January 2018.

3. The adequacy of referral management and whether it was reasonable for [Dr B] to refer [Mrs A] to the Department of General Surgery on 15 January 2018, including the timeliness of the referral.
4. Any other comments you may wish to make on the care provided to [Mrs A] by [Dr B].

[Dr C] (Waikato Hospital)

1. The standard of care provided to [Mrs A] by [Dr C].
2. Whether any further review, investigation or tests should have been undertaken when [Mrs A] was reviewed at Waikato Hospital on 9 May 2018.
3. The adequacy of referral management and whether it was reasonable for [Mrs A] to be referred back to Thames Hospital for a further colonoscopy, including the timeliness of the referral.
4. Whether the referral was appropriately prioritised on receipt by Thames Hospital?
5. Any other comments you may wish to make on the care provided to [Mrs A] by [Dr C].

For each question, please advise:

a) What is the standard of care/accepted practice?
b) If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) 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

- Letter of complaint dated 8 July 2020
- [Dr B's] response dated 6 August 2020
- WDHB's response dated 21 August 2020
- [Dr B's] response dated 15 March 2021
- WDHB's response dated 23 April 2021
- Clinical records from [medical centre]
- Not provided:
  - The DHB's incident review,
  - ACC's external clinical advisor's report.

Additional Resource

- Commissioning guide: Rectal bleeding. Association of coloproctology of Great Britain and Ireland. 2017.
- MOH. Standards for individuals performing national bowel screening colonoscopy in NZ. 2021.

- Factors influencing the miss rate of polyps in a back-back colonoscopy study. Leufkens et al. Endoscopy 2012; 44(05): 470–475.
- Colorectal cancer detected up to 5 years after normal colonoscopy/flexible sigmoidoscopy. Padmanabhan et al. Gut April 2011; vol 60, suppl 1.
- Diagnostic miss rate for colorectal cancer: an audit. Than et al. Ann Gastroenterol 2015 Jan-Mar; 28(1): 94–98.
- UK key performance indicators and quality assurance standards for colonoscopy. Rees et al. Gut 2016; 65:1923–1929.
- MOH. Referral criteria for direct access outpatient colonoscopy or computed tomography colonography. 2019.
- Routine retro flexion during colonoscopy has a low yield for neoplasia. Saad, Rex. WorldJGastroenterol 2008, Nove 14; 14(42): 6503–6505.
- Up-to-Date. Clinical guide for triaging patients with lower gastrointestinal symptoms. NICE guidelines 2020.
- NICE guidelines: Suspected cancer: recognition and referral: 1.3 Lower gastrointestinal tract cancers. Updated 2021.
- MOH website: Planned care services, Waiting time indicators.

Summary

On 3 November 2017, [Mrs A] was referred by her General Practitioner (GP) to the Gastroenterology Department at Waikato Hospital due to ongoing bleeding in her stool. On 27 November 2017, a flexible sigmoidoscopy was performed by [Dr B] at Thames Hospital, which was reported as normal. On 8 January 2018, [Mrs A's] GP referred her back to WDHB Coordination Centre as she had daily rectal bleeding. [Dr B] reviewed this referral and on the basis of the normal sigmoidoscopy on 27 November 2017, he passed the referral to the General Surgery Service via the WDHB Coordination Centre. [Mrs A] was put on a non-urgent outpatient waiting list. On 9 May 2018, [Mrs A] was reviewed by a Colorectal and Laparoscopic Surgeon, [Dr C], who referred [Mrs A] back to [Dr B] at Thames Hospital for a further colonoscopy. The letter of referral records that it was typed on 22 June 2018 and electronically approved and signed on 27 June 2018 by [Dr C]. In the meantime, [Mrs A] arranged to have [a private colonoscopy] on 12 June 2018. [Mrs A] was diagnosed with rectal cancer and it was reported that a large ulcerated rectal mass of approximately 4cm from the anal verge was found.

Summary of Questions.

<u>WDHB</u>

1. The timeliness of care provided to [Mrs A] and appropriateness of any waiting times.

   No deviation from standard of care.
   (**Maybe** a deviation from care as per endoscopy waiting times)

2. Whether there were any unnecessary delays in care or treatment.

   Minor deviation from standard of care.

Recommendation: Expectations around correspondence timeframes be developed.

3. Any issues concerning management of referrals between departments, including referrals between the General Surgery departments at Waikato Hospital and Thames Hospital, and the Gastroenterology department.

   No deviation from standard of care.

4. The adequacy of WDHB's policies and procedures.

   None provided.

5. Any other comments you may wish to make on the systems in place and the care provided to [Mrs A] as it relates to the failure to diagnose rectal cancer.

   No deviation from standard of care.

[Dr B] (Thames Hospital)

1. The standard of care provided to [Mrs A] in relation to the procedure performed on 27 November 2017.

   Minor deviation from standard of care.

   Recommendation: Review "Standards for individuals performing national bowel screening colonoscopy in NZ"

   Recommendation: Consider incorporating the recommendations under standard 3d on informed consent as a preformat part of endoscopy consent.

2. Whether any further review, investigation or tests should have been undertaken when [Mrs A] was referred back to WDHB by her GP in January 2018.

   No deviation from standard of care.

3. The adequacy of referral management and whether it was reasonable for [Dr B] to refer [Mrs A] to the Department of General Surgery on 15 January 2018, including the timeliness of the referral.

   No deviation from standard of care

4. Any other comments you may wish to make on the care provided to [Mrs A] by [Dr B].

   None

[Dr C] (Waikato Hospital)

1. The standard of care provided to [Mrs A] by [Dr C].

   Moderate deviation from standard of care.

2. Whether any further review, investigation or tests should have been undertaken when [Mrs A] was reviewed at Waikato Hospital on 9 May 2018.

   Moderate deviation from standard of care.

3. The adequacy of referral management and whether it was reasonable for [Mrs A] to be referred back to Thames Hospital for a further colonoscopy, including the timeliness of the referral.

   No deviation from standard of care.

4. Whether the referral was appropriately prioritised on receipt by Thames Hospital?

   Possible Failure to comply with MOH recommended timeframes. (See point 6)

5. Any other comments you may wish to make on the care provided to [Mrs A] by [Dr C].

   Minor deviation from standard of care.

6. **Recommendation:** WDHB develop and socialise their expectation of time frames around clinic letter management.

Discussion

I have reviewed this case and written the report from two review points. The first is whether WDHB had managed [Mrs A's] referral for rectal bleeding appropriately. The second is whether WDHB had taken appropriate care in their management at different points with the information available. This review must acknowledge that in any diagnostic process a significant diagnosis may be delayed or missed. This may not be a reflection of negligence or failure, it may be that, despite best care and intentions, a significant diagnosis was missed or delayed. My review is to evaluate if [Mrs A] was provided every appropriate opportunity to have her cancer diagnosed earlier.

WDHB

These questions relate to WDHB process and not to the individuals or final diagnosis as such.

The timeliness of care provided to [Mrs A] and appropriateness of any waiting times.

No *deviation from standard of care (see point 6. If my interpretation of waiting times is correct, this would be a deviation from KPI expectations.)*

1. The time lines are well delineated in multiple documents and I will not re-list them here.

2. The time from first referral to diagnostic procedure was appropriate. [Mrs A] was referred for unexplained rectal bleeding on 03 November 2017, a confirmation letter was sent on 05 November 2017 and she received a diagnostic flexible

sigmoidoscopy on 27 November 2017. This was within 42 days of receiving the referral. This time frame fits in with the referral criteria for direct access outpatient colonoscopy. It fits within the timeframe of Waikato's priority grading of the referral of priority 2, within 6 weeks.

3. [Mrs A] was referred back to Waikato DHB for persistent rectal bleeding on 08 January 2018.

4. Following a review by several departments in succession, [Mrs A] was accepted as a priority 4 (Routine, to be seen within 4 months) on 23 January 2018. This process took 15 days. This time frame fits with the MOH recommendations of processing a referral within 15 calendar days.

5. [Mrs A] was seen within 4 months (clinic appointment 09 May 2018) which fits the MOH guidelines of all patients to be seen within 4 months of receiving a referral.

6. [Mrs A] was listed for a colonoscopy as an outcome of her review at clinic 09 May 2017. [Mrs A] was sent a confirmation of the colonoscopy booking and the expectation of it to be done within 4 months as per letter 21 May 2018. The indicated waiting time ***may*** constitute a deviation from standard of care. My understanding is that circa 2016/17 the colonoscopy criteria consists of only three categories. Urgent, to be done within 14 days, Non-urgent, to be done within 42 days and surveillance. This was not a surveillance colonoscopy. The MOH KPI indicated that 70% of non-urgent colonoscopies are to be done within 42 days. 4 Months (120 days) for [Mrs A's] colonoscopy would be well outside the recommended waiting times. I will be happy to retract point 6 if my understanding of colonoscopy waiting times and the date they were initiated is incorrect. I was unable to find specific proof on the MOH website. I have extrapolated from KPI reports available stating the above timelines and dated 2016/17. Our own organisation's aspirational waiting time expectations align with my interpretation.

Whether there were any unnecessary delays in care or treatment.

Minor deviation *from standard of care relating to clinic correspondence*

Recommendation: WDHB develop or socialise their expectations to clinicians around clinic correspondence time frames, and if deemed appropriate, for all typed correspondence. Consideration should be given as to how correspondence will be managed if the responsible clinician is on extended leave.

7. The process [Mrs A's] second referral went through prior to being accepted may look disorganised or clumsy. This would be a fairly common process that referrals could go through as the individual services decide which would be the best service to see a patient. This evaluation process happens, to the best of my knowledge, in a very similar fashion in most hospitals. This is the result of the triage process happening in different places and at different times within organisations. This

requires the sending round of referrals to ensure that a referral is accepted by the most appropriate service.

8. All ***(with the caveat raised in point 6)*** the MOH timeframe recommendations were met. This is based on current recommendations. I am unable to comment confidently on what all the specific recommendations were in 2017. Newer recommendations generally have tighter time frames. I am confident therefore that if the current recommendations have been met, the 2017 recommendations would have been as well.

9. [Mrs A] was seen in [Dr C's] clinic on 09 May 2018. His clinic letter indicates that the clinic letter was typed on 16 May 2018. It was electronically approved on 27 June 2018. From clinic appointment to signing the letter is 48 days. [Dr C] states in his reply to the HDC that he cannot specifically recall the reason for this delay. There are no national guidelines around clinic correspondence timeframes that I could find. In our organisation we have localised expectations that all letters will be typed and signed within 7 days. If not, reminders are sent and an escalation pathway is followed. A letter confirming [Mrs A's] referral for colonoscopy is dated 21 May 2018. The referral letter from [Dr C] to [Dr B] in Thames Hospital is recorded as being typed on 22 June 2018 and approved on the 27 June 2018. Whilst [Dr C's] clinic correspondence was in my opinion unreasonably delayed, the referral for colonoscopy was sent with appropriate expedience. I consider the clinic correspondence overall therefore to be a **minor deviation** from standard of care as it did not delay the plan determined in clinic. The deviation would have been major had it directly influenced timely care being provided. I would consider the deviation moderate if the delayed information was critical to the future care plans but did not delay said care plans.

10. It is worth reflecting on the downstream effect such delays in correspondence may have on patient care. Delays in getting our clinic assessments and subsequent plans to GPs and colleagues prevents what may be valuable information from being available to be taken into consideration when planning further care. Reflect on the official referral letter being approved after [Mrs A] already had the colonoscopy in private.

Any issues concerning management of referrals between departments, including referrals between the General Surgery departments at Waikato Hospital and Thames Hospital, and the Gastroenterology department.

No *deviation from standard of care*

11. None. See point 7.

The adequacy of WDHB's policies and procedures.

12. None were provided

Any other comments you may wish to make on the systems in place and the care provided to [Mrs A] as it relates to the failure to diagnose rectal cancer.

No *deviation from standard of care.*

13. It would be reasonable to look back at the routine grading [Mrs A] received for her second referral. At the time, there was no reason to consider that a major pathology had been missed. The information at the time available to the triage process were:

    a. Colonoscopy in 2015 — microscopic colitis.
    b. Flexible sigmoidoscopy 27 November 2017 — normal.
    c. Blood tests — mildly abnormal faecal calprotectin, rest of tests normal.
    d. No red flag symptoms mentioned in referral letter.
    e. Red flag symptoms: Weight loss, change in bowel habit, anaemia, palpable mass.

14. I am confident that given the same set of circumstances being presented to a triage process across New Zealand that most, if not all, would triage the referral as routine.

[Dr B] (Thames Hospital) The standard of care provided to [Mrs A] in relation to the procedure performed on 27 November 2017.

Minor *deviation from standard of care relating to post endoscopy advice*

Recommendation: Review the NBSP standards and consider incorporating their standards where appropriate as a preformat part of the consent form.

[Dr B] performed a flexible sigmoidoscopy on [Mrs A] dated 27 November 2017. [Dr B] was accredited to perform endoscopy in Thames Hospital as per Dr ...'s letter to the HDC. The procedure was done with no sedation and is reported as well tolerated with no discomfort. The endoscope was passed to a distance of 120cm with a photo indicating the estimated proximal transverse colon was reached. Retro-flexion was done with a photo confirming it. (Some concerns discussed below.) I could find no documentation listing the withdraw time specifically, but 10 random biopsies were taken and the total procedure time was 23 minutes indicating that withdraw time was not excessively fast. In a later statement, [Dr B] states that he always performs a rectal examination (DRE) prior to starting a scope. Whilst it is not documented on the report, there is no reason to doubt this statement. Doing a DRE is recommended and standard practice as part of lower intestinal endoscopy, yet it is frequently not specified on the report. Since the launch of the national endoscopy quality improvement program (NEQIP) and the national bowel screening program (NBSP) in New Zealand, this part of the documentation has improved over the last few years. It continues to frequently be omitted on the report by endoscopists. Especially if it was normal. Note that no DRE is documented on [the] endoscopy report as a case in point. In the documents provided

for review there is a blown up photo of a retroflexed scope. The information on the photo identifies the photo taken on 27 November 2017 at 10:47:10 on [Mrs A]. This photo looks similar to the photos on the endoscopy report number 6. The report indicates it was taken in the rectum. The photo lacks identifying features to confirm its exact location. There is no reason to conclude that the rectum was not attempted to be fully examined in retroflexed position. This photo is only a snap shot of the examination and cannot be taken as representative of the completeness of the examination. I was unable to find guidelines on what ought to be visible on a retroflexed photo of the rectum. Personally I like for my photos to identify the dentate line as indication that the photo is taken in the distal rectum. The 27 November 2017 report states the endoscope was normal. From my review, a standard adequate endoscopy was performed that meets the key performance indicators. It is reasonable to state that the rectal cancer or mucosal abnormality was probably present at the time of this endoscopy but missed. It is unlikely that an interval cancer developed in the subsequent 6 months. Standard 3.1d of the document, Standards for individuals performing NBSP colonoscopy in NZ, lists the minimum requirements to be visible on the consent form. None of these are mentioned or visible on the flexible sigmoidoscopy consent form. This standard specifically lists "missed clinically important lesion rate (5–10%)". It is to be noted that these standards are dated 2021 and was likely not available in its current form at the time in 2017. International studies indicate that endoscopists miss significant pathology in 4% of cases. Whilst this figure includes a range of pathology, it also includes cancers. This figure reflects the miss rate of pathology despite best care and best practice application and is a reflection of the limitations of the investigation as a combination of equipment, the test itself, the operator and the colon as an organ. It is not a reflection of negligence. For all these reasons, I find no deviation from standard of care as it relates to the performance of a flexible sigmoidoscopy on [Mrs A] by [Dr B]. I am disappointed that [Mrs A] was discharged back to her GP after the completion of the endoscopy. [Mrs A] was referred for rectal bleeding and symptoms. No cause was found to explain the bleeding. The recommendations from endoscopy on further management plans or advice is absent. It simply states to continue present medications. If bleeding had stopped at the time of endoscopy, it would have been reasonable to refer [Mrs A] back to her GP for future review and management as appropriate. As [Mrs A] was referred back to WDHB with persistent bleeding within 6 weeks of the endoscopy, it is reasonable to assume the bleeding at the time of endoscopy was on-going. [Mrs A] should have had a proctoscopy as a more accurate method of evaluating presumed anal pathology as a cause of her bleeding after excluding a cause in the rectum and distal colon. Whether this proctoscopy should have been done as part of the flexible sigmoidoscopy can be debated. I personally feel that the proctoscopy should have been done on the day after the endoscopy did not show a cause. It is to be noted that [Mrs A] was referred for flexible sigmoidoscopy and haemorrhoid management if needed. At the very least, [Mrs A] should have been referred at this stage for further review of her rectal bleeding and or investigations at a surgical clinic. Alternatively, she should have been booked for a complete colonoscopy to look for other causes in the more proximal colon. Neither of these happened. This constitutes a **minor deviation** from standard of care. The deviation is considered minor as it is common practice to discharge patients

back to primary care following exclusion of sinister or major pathology. The endoscopy as performed had done so. The deviation does not relate to nor reflect the missed pathology as later diagnosed, but a missed opportunity to provide better care for a problem that had not been solved yet. It is worth reflecting that had a proctoscopy been done as part of the endoscopy evaluation, it may have showed the cancer. It may also have failed to show any significant pathology. In the latter it may have provided an opportunity to review rectal bleeding for which no cause had been established. This may have led on to further investigations that may have altered the diagnostic timeline. I appreciate the "maybes", however, the lack of excluding anal pathology in a timely fashion certainly denied any of the maybes from becoming a definite.

Whether any further review, investigation or tests should have been undertaken when [Mrs A] was referred back to WDHB by her GP in January 2018.

No *deviation from standard of care.*

The process of triage has already been discussed above and was appropriate. It was determined by the triage process that [Mrs A] should be seen in colorectal services for review. Her referral was graded as priority 4 based on normal investigations to date. This grading for presumed benign cause of rectal bleeding was appropriate. There was no reason at this stage to consider missed pathology or sinister causes relating to the information known at the time. I can identify no indication for direct access further investigations without a clinic appointment first, with the information known at the time.

The adequacy of referral management and whether it was reasonable for [Dr B] to refer [Mrs A] to the Department of General Surgery on 15 January 2018, including the timeliness of the referral.

No *deviation from standard of care.*

The referral and associated triage process around [Mrs A's] second referral in January 2018 was appropriate. [Dr B's] reason for sending the referral back, was to consider small bowel as a cause of bleeding in his opinion. His opinion was incorrect. The symptoms as described will come from a cause in the distal colorectal area, not the small bowel. [Dr B] having an incorrect opinion does not constitute a deviation from standard of care. This incorrect opinion had ultimately no influence on the management of the referral. As a general surgeon, [Dr B] would have been just as capable of seeing and evaluating rectal bleeding as would a specialist colorectal surgeon. This rerouting of the referral to, eventually, the colorectal surgeons, took only 2 days. The referral was graded routine by them on 23 January 2018. It is my opinion that the re-routing of the referral and [Dr B's] opinion, whilst non-sensical, is not a deviation from standard of care.

Any other comments you may wish to make on the care provided to [Mrs A] by [Dr B]. None.

[Dr C] (Waikato Hospital)

The standard of care provided to [Mrs A] by [Dr C].

Moderate *deviation from standard of care.*

[Mrs A] was seen by [Dr C] in his clinic on 09 May 2018. His letter does not indicate that he examined her, nor does it indicate why he did not examine her. In [Dr C's] reply to the HDC he is unable to recall the reasons for not examining her. At the time of clinic review [Mrs A] had rectal bleeding for more than 6 months. Colonic and rectal causes had already been excluded by the flexible sigmoidoscopy. The anal canal remained to be evaluated as a probable cause. It can only be done by DRE and proctoscopy. Most clinicians would also do a rigid sigmoidoscopy, but I would argue that the better test of the two (flexible sigmoidoscopy) had already been done. Omitting a rigid sigmoidoscopy in this scenario would be reasonable. The referral criteria for colonoscopy in similar circumstances would be persistent rectal bleeding with anal causes excluded. Whether the likely cause was thought to be from anal pathology or possibly from more proximal in the colon, a DRE and proctoscopy was a necessity to diagnose or exclude anal pathology. I consider this a **moderate deviation** from standard of care as [Dr C] did book [Mrs A] for a non-urgent colonoscopy and his clinic letter states that he expected an anal evaluation to be part of it. The deviation would have been minor to none had the colonoscopy been booked as urgent, to be done within 14 days. It would be reasonable to defer a DRE and proctoscopy in these circumstances to the endoscopy event as it is expected to happen urgently. The deviation would be major if neither had happened.

Whether any further review, investigation or tests should have been undertaken when [Mrs A] was reviewed at Waikato Hospital on 9 May 2018.

Moderate *deviation from standard of care.* In my opinion a thorough review should have included a proctoscopy and DRE. See points raised above.

The adequacy of referral management and whether it was reasonable for [Mrs A] to be referred back to Thames Hospital for a further colonoscopy, including the timeliness of the referral. ***No*** *deviation from standard of care.*

[Dr C] states in his letter that [Mrs A] requested her colonoscopy to be done in Thames Hospital. The referral to Thames is therefore appropriate. I note the delay in clinic correspondence from [Dr C's] clinic to the GP. The letter informing [Mrs A] of her colonoscopy booking is dated 21 May 2018. The referral booking for colonoscopy was therefore not delayed. Concerns around correspondence is discussed above and reflect a system deficiency, not a personal deficiency.

Whether the referral was appropriately prioritised on receipt by Thames Hospital?

Possible Failure *to comply with MOH recommended timeframes (see point 6).*

Any other comments you may wish to make on the care provided to [Mrs A] by [Dr C].

***Minor** deviation from standard of care relating to clinic correspondence.*

***Recommendation:** WDHB develop and socialise their expectation of time frames around clinic letter management.*

My opinion around correspondence and why I consider it a deviation from standard of care is discussed in points 9 and 10.

Comments on digital rectal examination (DRE)

A DRE is easy and quick to do. It is generally well tolerated by patients. It is, however, a test of variable value. The quality and reliability of the test depends on many variables: patient body habitus, patient discomfort, clinician experience, finger length, anal canal length and vigour of digitation. As a diagnostic, screening or exclusion test it is unreliable and should not influence the decision for further investigations. As a negative test result it is therefore of limited value. As a positive test it has a significant value as it becomes potentially diagnostic as well as determines the speed with which further investigations must happen. Omitting a DRE as part of anorectal evaluation remains a significant deviation from standard of care. It is worth noting that a DRE was performed by the GP on 23 May 2018 and potentially on 08 January 2018 and was found to be non-diagnostic. A DRE was done as part of the flexible sigmoidoscopy, 27 November 2017, and did not find anything. If we assume that the mass was present at these times, it serves to illustrate the variability of DRE, not a failure on the part of the clinicians. No DRE is recorded as part of the private colonoscopy. The tumour was palpable by [Dr C] in clinic on 11 July 2018. It is worth reflecting that had a DRE been done as part of the clinic visit on 09 May 2018, a significantly different timeline may have been proposed had it been palpated.

Comments on rectal bleeding

Visible rectal bleeding generally has a distal or lower intestinal cause. These sites are considered to be colon distal to splenic flexure, rectum and anal canal. The distal colon can only be evaluated by flexible endoscopy. The rectum can only be evaluated by rigid or flexible endoscopy. The anal canal can only be evaluated by a combination of DRE and proctoscopy. The evaluation of rectal bleeding must include in one form or another all of the above until a definitive diagnosis has been established. If at the conclusion of these tests no cause has been established, consideration should be given to missed pathology or a more proximal cause of bleeding. This should lead to further (colonoscopy) or repeat investigations as appropriate. Rectal bleeding is considered to have a low positive predictive value for colorectal cancer (8%). The causes of rectal bleeding are far more likely to be benign. The potential devastation of missing a cancer is such that we must endeavour to exclude this possibility first and foremost and without any doubt if possible. This can only be done by ensuring that the above investigations are done in an appropriate fashion and timeline. Omitting a test, or assuming a benign cause without due diligence is fraught, and not recommended.

Comments on the competency of [Dr B].

I take note of references to [Dr B's] competence in the letter from [Mrs A's husband] (parts redacted). I take note of Dr …'s letter referencing issues relating to [Dr B] (parts redacted). Unless there were known and specific concerns around [Dr B's] endoscopy ability at the time, these are not germane to the review in my opinion. Dr … stated in his reply to HDC that [Dr B] was trained by WDHB in endoscopy. His letter infers that multiple trainers had input into [Dr B's] training. Dr … lists DOPS as part of the endoscopy training program. Unless I am provided explicit concerns relating to [Dr B's] endoscopy ability prior to the event, I must assume that he was considered competent at the time. Subsequent to WDHB's review, other factors may have been uncovered. That remains outside of my review.

Comments relating to WDHB's reply to the HDC

In Dr …'s reply to the HDC, he indicates that WDHB have made significant changes to the endoscopy service. I assume he is referring to the standards and recommendations as documented and set out within the NEQIP program. Circa the time of this event, significant endoscopy quality improvement programs were initiated across New Zealand to standardise and improve the overall quality of endoscopy. These standards and recommendations will go a long way towards ensuring that the WDHB endoscopy service is as robust as it can be and minimise the risk of a similar event.

Gerrie Snyman'

The following further advice was provided to HDC by Dr Snyman on 16 January 2024:

'I have reviewed both my advice previously provided as well as the attached document of colonoscopy waiting times. In relation to my comments in point 6 on page 10 of my advice: The guidelines were for urgent colonoscopies to be done 90% within 14 days and 100% within 30 days, and, for routine colonoscopies to be done 70% within 42 days and 100% within 90 days. I take note of the following statement in the guideline on page 10 (unnumbered pages and counting front page): "Urgent, Non-Urgent and Surveillance colonoscopies have two clinically determined targets: the Recommended wait time indicator refers to the clinically appropriate timeframe a procedure **should** be completed within; if this target is not met, the patient **must** not wait longer than the Maximum wait time indicated. The Ministry monitors both Recommended wait times and the number of patients waiting over Maximum waiting times."

Waikato did not offer a colonoscopy to be available within this timeframe but within a timeframe of 120 days. This was well outside MOH guidelines. I would consider this to be a **moderate deviation from standard of care**. As this timeline was never tested it is speculation as to when the colonoscopy may have occurred, however the upfront time breach indicator of 120 days is sufficient for me to feel that this is a moderate departure from care for Waikato DHB as it signals that Waikato was not even [endeavoring] to adhere to the 90 days absolute boundary.'