Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 22HDC01701)

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Introduction

1. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Ms A by Dr B at Health New Zealand|Te Whatu Ora (Health NZ) Te Toka Tumai Auckland.[1]

3. The following issues were identified for investigation:

- *Whether Dr B provided Ms A with an appropriate standard of care in June 2022.*
- *Whether Health New Zealand|Te Whatu Ora provided Ms A with an appropriate standard of care in June 2022.*

[1] Formerly known as Te Whatu Ora|Health New Zealand. On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, resulting in all district health boards being disestablished.

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4. The parties directly involved in the investigation were:

Ms A	Consumer/complainant
Dr B[2]	Senior registrar
Health NZ	District healthcare provider

5. Also mentioned in the report:

Dr C	Junior registrar
Dr D	Registrar
Dr E	Senior medical officer (SMO)

6. Independent clinical advice was received from an experienced obstetrician and gynaecologist, Dr Celia Devenish (Appendix A).

Background

Introduction

7. On 13 June 2022, Ms A, a woman in her thirties, presented to Auckland City Hospital's Emergency Department (ED) with severe abdominal pain and reported that she was six weeks pregnant. Ms A told HDC that there was a delay in diagnosing her ectopic pregnancy[3] and a further delay in her receiving appropriate treatment. Following admission to the hospital, Ms A had her right fallopian tube[4] removed and she experienced 800ml of blood loss.

Timeline of events

8. At 7.48pm on 13 June 2022, Ms A presented to the ED following a referral from her general practitioner (GP). Ms A's partner accompanied her.

9. A nurse assessment was completed at 8.20pm. The assessment notes record that Ms A had a sudden onset of severe, sharp stabbing right lower abdominal pain that radiated to the rectum and there was discomfort on her right flank. There was no vaginal bleeding. At this point, urine and blood tests were also completed to check for potential causes of Ms A's symptoms, and to check her human chorionic gonadotrophin (hCG) level.[5]

10. Ms A's clinical notes initially indicated that she was given a triage category of five; however, the 'Triage data' document showed that Ms A was given a triage category of three.[6] Health

[2] Dr B was credentialled for basic gynaecology ultrasound scanning and had been performing transvaginal scans on a regular basis.

[3] A pregnancy in which the fertilised egg implants outside the uterus. In a normal pregnancy, the egg is implanted within the uterus.

[4] A tube along which eggs travel from the ovary to the uterus.

[5] hCG is a hormone produced by the body during pregnancy. It is used to test for pregnancy but can also assist in the diagnosis of abnormal pregnancies such as ectopic pregnancies.

[6] Guidelines developed by the Australasian College for Emergency Medicine (2016) state that Category 5 is the least urgent category, and indications for this include 'minimal pain with no high risk features'. The Guidelines

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NZ also confirmed to HDC that Ms A was given a score of three and that this was appropriate and consistent with the triaging guidelines.

11. At 10.05pm, Ms A was seen by an ED doctor, who advised Ms A that she had tested positive for the COVID-19 virus. From this point, Ms A was isolated and treated under COVID-19 precautions. In June 2022, some of New Zealand's historic COVID-19 restrictions had been lifted, but the country was still experiencing significant peaks in reported new community cases of COVID-19. The ED doctor referred Ms A to the Women's Health Service (WHS) for further management, as it was suspected that Ms A had an ectopic pregnancy.

12. At 11.17pm, Ms A was accepted by the WHS. However, she could not be transferred to the WHS because of a shortage of isolation beds.

Assessment by WHS registrars

13. At 1.05am on 14 June, Ms A was seen in the ED by a junior registrar, Dr C from the WHS. She was joined shortly afterwards by a senior registrar, Dr B, also from the WHS.

14. Dr B said that she was rostered to work in the labour and delivery unit that night but was called by Dr C to assist and complete a bedside transabdominal ultrasound scan.[7] Health NZ said that whilst it encourages registrars to work together overnight, the WHS registrar, Dr C, should have escalated to the Senior Medical Officer (SMO) on duty. It does not expect the registrar working in the labour and delivery unit to take responsibility for gynaecology patients.

15. Dr B understood that Dr C had completed a physical examination and a verbal history, and therefore Dr B undertook only a brief abdominal examination, which showed right lower quadrant abdominal tenderness. The clinical records do not indicate whether a physical examination or verbal history had been completed by Dr C.

16. Dr B assumed that Dr C had carried out a pelvic examination, as this was the standard practice for any patient presenting to the WHS with pain. Dr B did not perform a pelvic examination because of the increased acuity within the labour and delivery unit. Dr B also noted that there was mixed evidence regarding the specificity and necessity of a vaginal examination in the diagnosis of an ectopic pregnancy. Dr B did not mention having enquired about Dr C's pelvic examination findings.

17. Dr B said that as a transvaginal ultrasound scanner[8] was not available in the ED, Dr B completed a transabdominal ultrasound scan, which showed 'a [yolk] sac[9] visible in the uterus which was thought to possibly be a gestational sac[10] or a pseudo sac'. Dr B also said

state that assessment and treatment should start within 120 minutes. For category 3, assessment and treatment is to be started within 30 minutes, and an indication for this category includes 'moderately severe pain — any cause — requiring analgesia'.

[7] A scan used to visualise the abdominal anatomical structures.

[8] A scan used to visualise the reproductive organs.

[9] A yolk sac is a structure that develops inside the uterus during early pregnancy.

[10] A fluid-filled structure surrounding an embryo, which can be seen during the first few weeks of pregnancy.

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that there was no free fluid[11] in the abdomen, and the adnexa[12] could not be visualised easily. A copy of the transabdominal ultrasound scan result was not saved.

18. Health NZ confirmed that no transvaginal ultrasound scanning was available in the ED but said that this imaging could be carried out in the WHS ultrasound department overnight by a sonographer and this service is available 24/7. After hours, the transvaginal ultrasound scanner is ordered on a 'callout basis' reserved for urgent cases where acute surgery is contemplated overnight. Although a transvaginal ultrasound scanner is not available in the ED, Health NZ said that the sonographer could have been called in to the ED and could have brought the portable transvaginal ultrasound scanner.

19. Health NZ also stated that ultrasound examination in early pregnancy starts with a transabdominal ultrasound scan and is followed by a transvaginal ultrasound scan.

20. After the transabdominal ultrasound scan had been completed, Dr C documented the following:

> '[Intrauterine pregnancy][13] seen
>
> [No] fetal heart seen
>
> However still early to see [fetal heart]
>
> [No] free fluid
>
> Ectopic pregnancy ruled out.'

21. The blood test results were reviewed by Dr C, who noted that the white blood cell count and neutrophil count were elevated[14] and that Ms A's hCG level was 8,800IU/mL.[15] Ms A was also noted to have a mild fever.

22. Dr C documented that the clinical impression was possible appendicitis[16] and that an ectopic pregnancy had been ruled out.

23. Although Dr C recorded that an ectopic pregnancy had been excluded, Dr B said that she is certain that 'at no time did [she] exclude an ectopic pregnancy'. Dr B stated that the clinical notes were written without any input from her and without her knowledge. However, Dr B accepted that she should have written her own notes regarding the examination, or she should have checked that what Dr C had written was correct.

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[11] A fluid collection within the pelvic cavity can indicate an underlying disease process, such as inflammation or malignancy.

[12] The region adjoining the uterus. It contains the ovary and fallopian tube, as well as associated vessels, ligaments, and connective tissue.

[13] Pregnancy within the uterus.

[14] Increased white blood cell count can indicate infection or inflammation.

[15] The expected hCG range at six weeks' gestation is 1,080–56,500IU/mL.

[16] Inflammation of the appendix.

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24. Dr C's clinical notes record that the plan was to wait for a General Surgery review and a formal dating scan, as per the normal pregnancy pathway, and for Ms A to remain nil by mouth and receive intravenous fluids and pain relief. Fentanyl, morphine, and paracetamol were charted for pain relief. All the prescribed medications were administered to Ms A.

25. Dr C's plan did not state whether a formal transvaginal ultrasound scan was required. Dr B said she recalled advising that a formal transvaginal ultrasound scan needed to be arranged in the morning, or earlier if the pain continued, and she had assumed that the WHS would be carrying out the scan. She also said that she told Ms A and her partner that 'a formal scan' was required to confirm the pregnancy location.

26. Ms A stated: '[Dr C] told me that I should just get a formal dating scan which we already had booked in for the following week.'

27. Dr B said that she did not follow up on the transvaginal ultrasound scan referral because she was busy in the labour and delivery unit from that point on, and she had been rostered to work there that night. Health NZ said that it did not know whether Dr B was unaware of the availability of formal transvaginal ultrasound scanning overnight, but also that it is likely that Ms A's stable situation was the reason for not arranging a transvaginal ultrasound scan, rather than a lack of awareness.

Assessment by General Surgery team

28. At 2.40am on 14 June 2022, Ms A was seen by the General Surgery team, who completed an assessment and noted their impression as '[a]ppendicitis vs renal colic[17]'. The plan was for a formal transvaginal ultrasound scan to be completed in the morning and then a re-review following the ultrasound findings. In the meantime, Ms A was to remain nil by mouth and receive pain relief and intravenous fluids.

29. At around 4am, Ms A was transferred to the Clinical Decision Unit (CDU) of Health NZ because no beds were available in the WHS. Non-emergency cases requiring further assessment and investigation are generally transferred to the CDU to free up space within the ED and allow ED clinicians to tend to emergencies.

30. At 8.30am, Ms A was seen by the senior medical officer (SMO) during the acute surgical ward round. The General Surgery team noted that an ectopic pregnancy had been ruled out, and that Ms A had ongoing pain, nausea, and tenderness. A plan was made to wait for the formal transvaginal and transabdominal ultrasound scan and repeat Ms A's blood tests. It was noted that Ms A had tested positive for COVID-19 via a rapid antigen test on 13 June but that she was not exhibiting any COVID-19 symptoms.

31. At 10.46am, a formal transabdominal and transvaginal ultrasound scan was completed. The report indicated a moderate volume of fluid in the lower abdomen and a complex mass consistent with a ruptured ectopic pregnancy. The radiologist alerted the General Surgery

[17] Pain caused by a stone in the upper urinary tract.

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team to these results and advised the team to refer Ms A to the Gynaecology team for further assessment.

32. Health NZ said that given Ms A's stable condition overnight, and the impression of an intrauterine pregnancy initially, it was clinically appropriate for the transvaginal ultrasound scan to be completed in the morning.

33. Health NZ said that after 10.46am, the General Surgery team had no further involvement in Ms A's care.

34. At 12.30pm, Ms A was reviewed by another WHS registrar, Dr D, who noted the finding of a ruptured ectopic pregnancy. She completed an assessment and informed Ms A that she would need to go to theatre for a laparoscopic salpingectomy.[18] Ms A said that Dr D apologised for the misdiagnosis and for letting her down.

35. Ms A told HDC that she was advised by Dr D that she would go to theatre within the next 30 minutes, but she was not called to theatre until 2.45pm. Health NZ said that the time between the decision for surgery and the time to arrival in theatre was 2 hours 22 minutes, which is 'not outside the normal for this type of case, within the competing demands on the acute theatre resource'. Health NZ said that the delay in getting to theatre occurred in part because Ms A needed to be transferred by the hospital COVID-19 transfer team, who ensured direct transfer from the patient's isolation area to the operating theatre, clearing corridors and holding lifts on the way to minimise contact with other patients in shared clinical areas.

36. At 12.50pm Dr D documented that Ms A had also tested positive for COVID-19 earlier in the year (in March 2022) but currently had no respiratory symptoms. Dr D also noted that Ms A had tested positive on the rapid COVID-19 swab, which 'indicates still high load of nucleic acid'. Clinical records note that this was discussed with the virology registrar, and Ms A was advised to remain under COVID-19 precautions. Health NZ stated: 'With no certain onset of symptoms in this situation it would have been inappropriate to treat [Ms A] as non-[infectious].'

37. Clinical notes record that Ms A entered theatre at 3.12pm and the procedure was completed at 5.28pm. Postoperative notes record that the surgery was carried out under COVID-19 precautions and that there was an 800ml blood loss. Ms A was transferred to the WHS at 6.20pm for postoperative management.

38. At 6.10pm on 14 June, Dr D documented:

> '[Polymerase chain reaction test for COVID-19] has returned negative. ?Rapid [point of care testing] may indicate either false [positive] or mildly elevated (ongoing) [messenger RNA] from previous infection.'

[18] Removal of a fallopian tube.

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39. Dr D's plan included another rapid antigen COVID-19 test and for Ms A to be de-isolated if this was negative.

40. At 8.12am on 15 June, a WHS registrar recorded that Ms A was 'debriefed over [the] events' of 13/14 June and that Ms A was upset because 'overnight [she] had [had two] registrars scan her and [tell] her [that she had an intrauterine pregnancy] which gave her false reassurance'. Ms A said that this WHS registrar had been unaware of the events until she had raised her concerns. Ms A was then advised that an internal review would occur and that she could also make a formal complaint.

41. A further clinical note at 8.50am states that the WHS team apologised to Ms A for the inconsistencies in the information given to her. Ms A said that this occurred only after she had raised her concerns with the registrar who saw her at 8.15am on 15 June, and although an apology was received, the WHS team had put blame on 'system problems'.

Subsequent events

42. Health NZ and Dr B apologised to Ms A for the pain and stress experienced due to the delay in their service.

43. Health NZ completed a review of Ms A's care as part of the gynaecology morbidity and mortality meeting. The findings of the review were shared with Ms A. The main findings were as follows:

- There was a delay in the diagnosis of an ectopic pregnancy by eight hours, which resulted in a ruptured fallopian tube, which was an avoidable event.
- There was a further five-hour delay in Ms A receiving surgical treatment.
- The transabdominal ultrasound scan completed in the ED was not saved because the WHS registrars were not aware that this was possible.
- A formal transvaginal ultrasound scan was not requested by the WHS when this was possible in the WHS overnight.
- The acute gynaecology pathway for early pregnancy was not followed.
- There was poor communication from clinical staff in the ED and the ward.

44. The gynaecology morbidity and mortality review recorded that registrars need to be notified that it is possible to save scanned ultrasound images if using the ED ultrasound scanner, and that registrars need to be reminded that it is always possible to request an overnight transvaginal ultrasound scan in the WHS ultrasound department, or the sonographer can come to the ED if the patient is unwell.

45. Health NZ told HDC that the eventual outcome for Ms A, which was surgical management of an ectopic pregnancy, would have been the same if a formal transvaginal ultrasound scan had been done soon after admission. However, Health NZ was unsure whether surgery would have been done sooner, due to usual acuity overnight in acute theatres.

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46. Ms A said that Dr B called her and apologised for the events, but the apology occurred at a time when it was not suitable for Ms A to talk on the phone. Health NZ said that Dr B took responsibility for the incorrect diagnosis on 14 June 2022.

47. On 12 July 2022 a telephone conference was held between Ms A and her partner and a senior clinician from the WHS. Ms A was given the opportunity to discuss her concerns. Health NZ acknowledged Ms A's frightening and disappointing experience and again apologised for the events that unfolded on 13/14 June. It was noted that the loss of a fallopian tube most likely would have occurred even if the tube had not ruptured, and that trying to save the tube by removing the ectopic pregnancy would have increased the likelihood of a later rupture.

48. Ms A said that she was not aware that the telephone conference of 12 July would be her only opportunity to discuss her concerns, and she would have prepared for this call had she known that this would be the case.

Further information

49. Dr E was the SMO from the WHS on call overnight on 13/14 June 2022. Dr E stated that she was not telephoned by Dr B or Dr C for assistance.

50. Health NZ said that between 7pm and 7am on 13/14 June 2022, the ED was short-staffed by five registered nurses and three doctors, and on those days the ED had high volumes and high acuity of patients.

51. Dr B said that she had recently returned from leave and did not have a return-to-work programme to ensure that she was up to date with the latest guidelines, especially gynaecology pathways.

Responses to provisional report

Ms A

52. Ms A was provided with a copy of the 'information gathered' section of the provisional report and given an opportunity to comment. Ms A said that she disagrees that Dr B took responsibility for the incorrect diagnosis on 14 June. Ms A said she understands that mistakes happen but emphasised that how people are treated in the aftermath is very important. She stated that Dr B not taking full responsibility for her actions made the experience more traumatic and created a loss of trust in health professionals. Ms A said that she would have 'liked a restorative practice approach in the aftermath of this adverse event', which may have allowed Dr B to have taken responsibility of her actions in this setting. Other comments from Ms A in response to the provisional opinion have been integrated throughout this report as appropriate.

Dr B

53. Dr B was provided with a copy of the provisional report and given an opportunity to comment. Dr B confirmed to HDC that she had no comments to make.

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Health NZ

54. Health NZ was provided with a copy of the provisional report and given an opportunity to comment. Health NZ commended Dr B for her commitment to learning from this event, including reviewing the ultrasound images of the formal scan with an expert for her own learning, whereby she now understands that her findings were consistent with a pseudosac. Health NZ said that it regrets not providing Dr B with an opportunity to respond to the initial HDC complaint, and not providing images of the formal scan to the independent advisor.

Opinion: Introduction

55. First, I acknowledge the challenging events experienced by Ms A and her partner in June 2022. An ectopic pregnancy is an extremely distressing situation, and for this Ms A has my deepest sympathies. I commend Ms A for sharing her experience openly, as this case has highlighted several areas for improvement.

56. At 7.48pm on 13 June 2022, Ms A presented to Health NZ's ED with severe abdominal pain and a suspected ectopic pregnancy. At 1.05am on 14 June, Ms A was seen by a senior registrar from the WHS, Dr B, and a junior registrar, Dr C. Dr B had been rostered to work within the labour and delivery unit, but Dr C had called on her to assist. Dr B completed a bedside transabdominal ultrasound scan in the WHS, and clinical notes documented that Ms A did not have an ectopic pregnancy. The WHS registrars did not order a formal transvaginal ultrasound scan to confirm this diagnosis.

57. Fortunately, the General Surgery team ordered a transabdominal and transvaginal ultrasound scan some eight hours later, which showed that Ms A had a ruptured ectopic pregnancy. Health NZ's AER concluded that there was a delay in diagnosis of Ms A's ectopic pregnancy by eight hours, and a further delay of five hours in her receiving surgical treatment. Ms A reported that her mental health was profoundly affected by these events and resulted in a loss of faith in Health NZ's ability to provide quality care.

58. To help me determine whether the care provided was of an appropriate standard, I sought independent advice from an experienced gynaecologist and obstetrician, Dr Celia Devenish. I have included relevant advice from Dr Devenish throughout my opinion.

Opinion: Dr B — breach

59. As the senior registrar involved in Ms A's care, Dr B had a responsibility to provide care to Ms A in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). Although an SMO from the WHS was on call overnight on 13/14 June 2022, the SMO was unaware of this case and was not consulted or called upon by Dr B.

60. Having carefully reviewed all the information on file, including the responses provided by Health NZ, Dr B, and Ms A, I have identified deficiencies in the standard of care and communication provided to Ms A by Dr B.

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61. I accept that several important considerations made the management of this case difficult at the time, including the following:

a) Dr B had not received a return-to-work programme to ensure that she was up to date with the latest guidelines, especially the gynaecology pathways.

b) Auckland City Hospital's ED was short of registered nurses and doctors on 13/14 June 2022 with the ED experiencing high volumes and high acuity of patients on these days. Other departments within the hospital, including the labour and delivery unit and operating theatres, were also experiencing acute demand, which meant that clinical staff were carrying heavy workloads and were operating under pressure.

c) The clinical management of Ms A was further challenged by the COVID-19 precautions in place at the hospital at the time.

62. I have carefully reviewed the circumstances of this case and consider that the onus remains on the responsible clinician for providing an acceptable level of care. In my opinion, there were three key issues in Dr B's care of Ms A. I have set out my decision and the reasons for this below.

Diagnosis of intrauterine pregnancy without formal transvaginal ultrasound scan

63. Ms A expressed concern about the misdiagnosis of an intrauterine pregnancy by the WHS registrars. Ms A told HDC that Dr B ruled out an ectopic pregnancy and 'confirmed that [Ms A] had an [intrauterine] pregnancy' by showing her and her partner the yolk sac during the bedside transabdominal ultrasound scan.

64. Dr B disagreed with Ms A's version of events and is certain that she did not exclude an ectopic pregnancy during her assessment. Dr B said that she did not state that there was a pregnancy, but that there was a sac within the uterus, which could represent an early pregnancy. She said that there was increased echogenic[19] material within the uterus, which had looked like a potential fetal pole[20] and possibly a yolk sac. Dr B said that it is possible that what she saw in the uterus was a pseudo sac.

65. Health NZ said that the quality of ultrasound images is influenced by several factors, such as equipment, body habitus, and the experience of the operator. In this case, the initial transabdominal ultrasound scan detected material in the uterus that could have been interpreted as either a gestational sac or a pseudo sac. However, Health NZ accepted that an intrauterine pregnancy could not be proven definitely.

66. Dr B did not save a copy of the transabdominal ultrasound scan completed in the ED. However, clinical records written by Dr C on behalf of Dr B record that the transabdominal ultrasound scan was interpreted as showing that an intrauterine pregnancy was present and that an ectopic pregnancy had been ruled out. Dr B said that the clinical record was written

[19] How bright or dark something appears in the gray-scale ultrasound image.
[20] One of the first stages of an embryo's development in pregnancy.

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without any input from her and without her knowledge. Nevertheless, Dr B accepted that she failed to read the notes written on her behalf by Dr C.

67. Dr Devenish advised that an ectopic pregnancy cannot be excluded on a transabdominal ultrasound scan alone, and that arranging a transvaginal ultrasound scan was a priority and the accepted standard of care. The clinical notes do not document whether a transvaginal ultrasound scan was considered or ordered.

68. Ms A told HDC that at no time did Dr B or Dr C inform her that a transabdominal ultrasound scan was not appropriate for ruling out an ectopic pregnancy. Ms A said that not being informed of this took away her ability to advocate for herself and her family.

69. Dr B said that she was aware from her experience and training that a transvaginal ultrasound scan was necessary for diagnosis. She stated that as a transvaginal ultrasound scan was not available within the ED, she completed the transabdominal ultrasound scan but recommended that a transvaginal ultrasound scan be arranged to confirm an intrauterine pregnancy in the morning, or earlier if Ms A's pain continued. Dr B also said that she advised Ms A that a 'formal scan' would be required to confirm the intrauterine pregnancy.

70. Health NZ said that an ectopic pregnancy usually (but not always) presents with vaginal bleeding as well as pain. Health NZ said that as Ms A did not present with vaginal bleeding, this may have steered the differential diagnosis to other causes of pain. Nevertheless, Health NZ accepted that an ectopic pregnancy should have been excluded by way of a formal transvaginal ultrasound scan.

71. Dr Devenish advised that the diagnosis of intrauterine pregnancy in the absence of a transvaginal ultrasound scan was a moderate departure from the accepted standard of care. I accept this advice.

72. I acknowledge Dr B's view that she saw a pseudo sac, that she did not rule out an ectopic pregnancy, and that she had assumed that a transvaginal ultrasound scan was being arranged. However, when forming a decision, I endeavour to base it on facts, and in the absence of the transabdominal ultrasound scan image and Dr B's documentation of her findings, I am unable to validate Dr B's reasoning. Therefore, I place more weight on Dr C's contemporaneous documentation, which largely supports Ms A's account of events.

Inadequate clinical examination

73. Dr Devenish considers that the lack of clinical and pelvic examination contributed to Ms A's misdiagnosis. Dr Devenish advised that a pelvic examination would have been beneficial prior to ultrasound scanning because this may have confirmed cervical movement tenderness, and there may have been a change in findings. Dr Devenish said that even if Dr B relied on a junior registrar and believed the registrar was capable, usually seniors would perform an examination before an ultrasound to exclude causes of pain, including ectopic pregnancy. Dr Devenish's advice is supported by Health NZ's policy ('Ectopic Pregnancy — Diagnosis and Management in Gynaecology and Maternal Fetal Medicine), which reiterates

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the need for a repeat clinical examination if there is uncertainty around possible ectopic pregnancy.

74. The clinical records do not document whether a pelvic examination was undertaken. There is evidence that a verbal history was undertaken by other clinical staff (which identified shoulder tip pain), but it is not known whether Dr B reviewed this history.

75. Dr B said that she completed a brief abdominal examination (which showed right lower quadrant abdominal tenderness) but she did not perform a pelvic examination as she had assumed that Dr C had completed this, because it was standard practice for any patient presenting to the WHS with pain. However, Dr B also said that there was mixed evidence regarding the specificity and necessity of pelvic examination in the diagnosis of ectopic pregnancy.

76. Dr B said that her involvement in Ms A's direct care was performing the transabdominal ultrasound scan as requested by Dr C. However, Dr B accepted that she should have taken a detailed history from Ms A, and that not doing so resulted in missing the information relating to the shoulder tip pain. Dr B acknowledged that had this been done, she would have been more likely to focus on the diagnosis of an ectopic pregnancy and question what she had seen in the uterus.

77. Dr Devenish advised that not completing a pelvic examination prior to the transabdominal ultrasound scan was a minor deviation from the expected standard of care. I accept this advice. While I acknowledge that Dr B was called to assist only with the transabdominal ultrasound, and that she completed a brief abdominal examination, I consider that in this case, a more thorough clinical examination, including a pelvic examination, would have assisted in the interpretation of the ultrasound imaging and confirmation as to whether this was an intrauterine pregnancy or an ectopic pregnancy.

Inadequate documentation

78. Dr B did not document her transabdominal ultrasound scan findings or her abdominal examination findings, or that a transvaginal ultrasound scan was required to confirm an intrauterine pregnancy. Dr B accepted that she should have checked Dr C's documentation to ensure that his record was accurate.

79. Dr Devenish advised that in the context of Dr B assisting a junior registrar, the failure to document was a mild deviation from the standard of care. I accept this advice. I consider that in this case thorough documentation would have served as an additional mechanism for capturing a more accurate account of what was found during the bedside transabdominal ultrasound scan and would have helped to clarify any misunderstandings held by Dr C and Ms A. In addition, the lack of documentation of the need for a transvaginal ultrasound scan prevented other clinical staff from following up with this action.

80. I acknowledge the heavy demands placed on health professionals in relation to contemporaneous record-keeping during busy periods. However, clear records reflect a doctor's reasoning and are an important source of information about the patient's care. The

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Medical Council of New Zealand requires doctors to maintain clear and accurate patient records that report relevant clinical findings and decisions made, and the reasons for them. Accurate and complete clinical documentation is therefore a cornerstone of good care, and a required standard of professional practice. It enables more effective communication between clinicians to ensure appropriate continuity of care for the patient. In addition, poor clinical notes hamper later inquiry into what happened — thereby compromising the opportunity to address issues raised by or on behalf of a consumer, as well as quality improvement measures that may flow from such inquiry.

Conclusion

81. Although Dr B was rostered to work in the labour and delivery unit, by agreeing to support the junior registrar, Dr B was responsible for ensuring that Ms A received an appropriate standard of care. The misdiagnosis of an intrauterine pregnancy, the lack of a thorough clinical examination, and the lack of documentation of the ultrasound findings and a plan of care created additional risk for Ms A.

82. Therefore, I find Dr B in breach of Right 4(1) of the Code,[21] for the following reasons:

- The exclusion of an ectopic pregnancy in the absence of a transvaginal ultrasound scan;
- The lack of a thorough clinical examination, including a pelvic examination; and
- The lack of documentation of the transabdominal ultrasound scan findings and the recommendation to arrange a transvaginal ultrasound scan.

Opinion: Health NZ|Te Whatu Ora Te Toka Tumai Auckland — adverse comment

Introduction

83. As a healthcare provider, Health NZ has an organisational responsibility to provide services in accordance with the Code. I have considered whether any systems issues affected Ms A's care and have identified a single area of concern, as set out below, and a further matter where the management of ectopic pregnancies may be improved with further education.

Delay in completing formal transvaginal ultrasound scan — educational comment

84. As noted above, a transvaginal ultrasound scan was necessary to exclude an ectopic pregnancy, and this was a priority. However, clinical records show that this was not documented, arranged, or followed up by the registrars from the WHS.

85. A transvaginal ultrasound scanner was not available in the ED. Health NZ told HDC that it does not think that a transvaginal ultrasound scanner would have prevented delays in this case. Health NZ said that although no transvaginal ultrasound machine was available within the ED, this could have been obtained from the WHS overnight if required, or the

[21] The right to have services provided with reasonable care and skill.

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sonographer could have been called to the ED. However, it appears that Dr B was unaware of this, as she said that a plan was made to arrange for this in the morning.

86. In response to the provisional report, Health NZ said that it does not know whether Dr B was unaware of the availability of a formal transvaginal ultrasound scanner overnight. Health NZ stated that given Ms A's stable condition overnight and the impression of an intrauterine pregnancy initially, it was clinically appropriate to complete the transvaginal ultrasound scan in the morning. Therefore, it told HDC that the stable condition of Ms A was the reason for not trying to arrange a formal transvaginal ultrasound scan under COVID-19 precautions overnight, rather than a lack of awareness. In contrast, Health NZ's gynaecology morbidity and mortality meeting case review noted that the WHS registrars needed to be reminded that a transvaginal ultrasound scan was possible overnight, suggesting that the registrars were not aware of this.

87. Dr B also said that she assumed that the WHS would be ordering the transvaginal ultrasound scan, and she acknowledged that she did not follow up on this because she was busy within the labour and delivery unit overnight.

88. I am concerned that WHS staff were not aware of the availability of transvaginal ultrasound scanning within the WHS overnight. Ectopic pregnancies are not an uncommon presentation in the ED, and I consider that in this situation, the delay in diagnosis of Ms A's ectopic pregnancy was in part a consequence of a shortcoming in Health NZ's induction and training system, which meant that WHS registrars were not aware of the availability of transvaginal ultrasound scans overnight.

Acute gynaecology pathway — adverse comment

89. Ms A was started on the acute gynaecology pathway, which is a nurse-led pathway for ED nurses and gynaecology nurses to guide initial investigation, escalation, and placement of patients who present with gynaecology concerns.

90. Dr Devenish advised that the acute gynaecology pathway was not followed in Ms A's case. This is because she was noted as having an orange flag for abdominal pain of over 5/10, which meant that Ms A needed to be admitted to the WHS and have a formal transvaginal ultrasound scan completed. Dr Devenish advised that the failure by WHS staff to follow the acute gynaecology pathway was a mild deviation from the expected standard of care.

91. Health NZ said that the acute pathway was followed as intended, and there was no deviation from the expected standard of care. Health NZ stated that technically Ms A did not fit the inclusion criteria for the pathway due to the absence of vaginal bleeding, but the ED team still placed her on this pathway.

92. Health NZ said that for a person with an orange flag of abdominal pain measuring 5/10, Ms A should have been kept in the ED's acute area, and the WHS registrar should have been informed and a medical assessment undertaken by the ED doctor. The ED doctor did see Ms A and document an assessment, and this was then discussed with the WHS registrar, who

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accepted the patient. Health NZ said that therefore, the acute gynaecology pathway was followed as intended, and there was no deviation from the expected standard of care.

93. In response to Health NZ, Dr Devenish advised that the acute gynaecology pathway for a pregnant patient presenting with pain (irrespective of bleeding or not) should mention the need for transvaginal ultrasound to exclude an ectopic pregnancy. I accept this important aspect of Dr Devenish's advice. Whilst I accept Health NZ's submission that the gynaecology pathway was followed as intended, I am concerned that the acute gynaecology pathway did not state the need for a formal transvaginal ultrasound scan. Health NZ agreed that the wording could be clearer to say that a formal transvaginal ultrasound scan should be requested regardless of whether a transabdominal ultrasound scan has been carried out in the ED.

Delay in accessing theatre — no breach

94. Ms A queried whether her COVID-19 diagnosis delayed her surgical treatment. Initially, Health NZ said that there was a five-hour delay in Ms A receiving surgery. In a further statement, Health NZ said that there was a delay of only two hours and 22 minutes before Ms A was called to theatre. However, Health NZ said that even if a formal transvaginal ultrasound scan had been completed sooner, the surgery may not have occurred earlier due to the usual acuity overnight in acute theatres.

95. The clinical notes record that Ms A's COVID-19 infection was reviewed by the infectious diseases specialist, who advised that Ms A needed to remain isolated. There is also evidence of a positive COVID-19 test. Under these circumstances, in my view the need for extra precautions was reasonable to minimise possible contact with other at-risk patients and health professionals working in the environment.

96. Dr Devenish said that given the COVID-19 protocols, the delay in accessing theatre was inevitable. She stated that the need to close theatres and minimise the risk for staff becoming infected as result of possible cross-contamination was a serious concern. As such, Dr Devenish advised that there was no departure from the accepted standard of care. I accept this advice.

Delay in formal transvaginal ultrasound scan — no breach

97. Health NZ said that there was a delay of eight hours in Ms A receiving a formal transvaginal ultrasound scan. Dr Devenish advised that this timeframe was reasonable given the workload experienced by ultrasound departments and the need for additional precautions with a potential COVID-19 positive patient. Dr Devenish noted that over this period, Ms A's clinical assessment was undertaken and her vital signs remained unchanged, which suggested that there were no signs of clinical compromise and no immediate urgency for intervention. I accept this advice.

800ml blood loss — no breach

98. Ms A expressed concern about the 800ml blood loss during her surgical procedure and queried whether this occurred because of the delays in her care. Postoperative clinical notes

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confirm a blood loss of 800ml. Dr Devenish advised that the blood loss would have occurred over at least 12 hours and, in retrospect, it cannot be known when the accumulated blood loss occurred, and most likely it happened slowly over several hours. Dr Devenish said that as there was no blood transfusion during the procedure, and Ms A's vital signs remained stable, this suggested that there was no critical blood loss and that Ms A was not clinically compromised. As such, Dr Devenish advised that there was no departure from the accepted standard of care. I accept this advice.

ED triaging — no breach

99. Ms A expressed concern over the appropriateness of the triage score given to her on presentation to the ED. Clinical records initially provided to HDC showed that Ms A's ED triage score was five. However, Health NZ said that the triage score was three, and, in response to the provisional report, Health NZ provided a copy of the 'triage data' sheet, which confirmed that the triage score was three. Clinical records show that Ms A was admitted to the ED at 7.48pm on 13 June and was seen by the ED doctor at 10.05pm. Dr Devenish advised that while a triage score of five is low for a pregnant woman with pain, the 2.25-hour wait time to be assessed by an ED doctor was in accordance with a triage category of three. As such, Dr Devenish advised that there was no deviation from the expected standard of care. I accept this advice.

Conclusion

100. There appears to have been a lack of awareness of staff about the access to ultrasounds in the WHS overnight, and an accompanying lack of clarity in the acute gynaecology pathway about the need for a transvaginal ultrasound to be completed in particular circumstances. However, I do not consider that these shortcomings reflect major systems failures within Health NZ. Therefore, I consider that Health NZ did not breach the Code.

Changes made since events

Dr B

101. Dr B said that she has reflected on her practice and made the following changes:

a) She writes all her own clinical notes after assessing patients. In situations where this is not possible, she always checks the clinical notes to ensure that they capture what she has seen, said, or done.

b) She examines patients herself in order to make a diagnosis. Where she is unable to do this, she reviews the clinical notes to ensure that the correct examination has been performed and an accurate conclusion drawn.

c) She has reviewed the ectopic pregnancy pathways at Health NZ, as well as the Royal College of Obstetricians and Gynaecologists' guidelines and the American Society of Reproductive Medicine's guidelines to ensure that she is practising the most up-to-date medicine.

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d) She now looks up guidelines when dealing with cases with which she is not familiar, as she is aware that Health NZ's guidelines and pathways can change and be updated. She also prepares herself with the latest guidelines and pathways before entering work environments after being away from work for an extended period.

e) She is more vigilant when completing pregnancy scans, with Ms A's case being in the forefront of her mind when performing each scan.

f) She has undertaken teaching with the registrars regarding early pregnancy assessments.

g) She has attended an education session with the ultrasound department, where the ultrasound sonographers went over what she saw intrauterine and on the transvaginal scans, and details were discussed regarding pseudo sacs and the trickiness of diagnosis. Dr B advised that this session is now strongly embedded in her practice for every woman for whom she performs an early pregnancy scan.

h) She has attended an early pregnancy scan course overseas to ensure that she is meeting the standards of assessment, and that her skills are proficient for the level of care she needs to provide.

i) She has undertaken communication workshops online through the Medical Protection Society and listened to educational webinars, to improve her communication skills with her colleagues and ensure that what she has said is documented and understood correctly.

j) She has undertaken education around open disclosure to further ensure that the care she provides to patients is acceptable and that if there are actions that do not follow protocol or cause an adverse event, they are communicated effectively.

k) She will support doctors returning from extended leave by checking to see that they are given an induction or a return-to-work programme.

Health NZ Te Toka Tumai Auckland

102. Health NZ said that it has made, or will make, the following changes:

a) It will remind registrars that it is possible to save scanned images if using the transabdominal ultrasound scan machine within the ED.

b) It will remind registrars about the acute gynaecology pathway.

c) It will remind registrars that it is always possible to request an overnight transvaginal ultrasound scan from the WHS department, and the ultrasound sonographer can come to the ED if the patient is very unwell.

d) It will change the acute gynaecology pathway to say that if a transabdominal ultrasound scan is performed for a pregnant patient in the ED, then a transvaginal ultrasound also needs to be completed, no later than the next day.

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e) It has provided feedback to the WHS clinicians that a formal ultrasound is to be arranged for patients presenting with pain and bleeding in early pregnancy, within 24 hours of arrival at the hospital, regardless of the level of hCG or severity of pain.

Recommendations

103. I acknowledge the extensive changes already made by Dr B. In addition, I recommend that Dr B provide a formal written apology to Ms A for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

104. I acknowledge the changes made by Health NZ. In addition, I recommend that Health NZ Te Toka Tumai Auckland:

a) Provide a formal written apology to Ms A for the deficiencies identified within this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A.

b) Confirm to HDC that it has implemented the actions in paragraph 102 (a) to (d), within two months of the date of this report.

c) Establish a return-to-work programme within the WHS for clinicians returning from extended leave. An update on this recommendation is to be provided to HDC within three months of the date of this report.

d) Amend its acute gynaecology pathway for pregnancy to indicate that a transvaginal ultrasound is to be completed for all women presenting with pain (irrespective of bleeding or not), to exclude ectopic pregnancy. A copy of this amended pathway is to be provided to HDC within three months of the date of this report.

Follow-up actions

105. A copy of this report with details identifying the parties removed, except the advisor on this case, Auckland City Hospital, and Health New Zealand|Te Whatu Ora Te Toka Tumai Auckland, will be sent to Te Tāhū Hauora|Health Quality & Safety Commission and the Medical Council of New Zealand. The Medical Council of New Zealand will be advised of Dr B's name.

106. A copy of this report with details identifying the parties removed, except the advisor on this case, Auckland City Hospital, and Health New Zealand|Te Whatu Ora Te Toka Tumai Auckland, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to Deputy Commissioner

The following clinical advice was obtained from Dr Celia Devenish:

> 'I have been asked to provide an opinion to the Commissioner for the above. I have read the Commissioner's guidelines and I agree to follow these guidelines.
>
> I am a Specialist Obstetrician and Gynaecologist, working within a generalist scope of practice, and have been accredited with Fellowship of both RANZCOG and RCOG.
>
> I have practised as a Consultant in both Obstetrics & Gynaecology for 40 years in both tertiary and secondary provincial centres, in public, academic, rural and private practice sessions.
>
> I have worked in a joint clinical and academic position, as a Specialist at Dunedin Hospital for 21 years. I have been Clinical Leader in Obstetrics.
>
> As an Otago University Senior Lecturer, I am involved in research and teaching in the Dunedin School of Medicine at undergraduate and postgraduate levels. I am the current Chair of the SIMG Committee for New Zealand, Southern ITP Co-ordinator and a Training Supervisor and Train the Trainer facilitator. I am involved in specialist training and organise various clinical workshops in NZ.
>
> I am a past RANZCOG Board and Council member where I chaired and sat on various committees including the FRANZCOG and DRANZCOG Examination Committees. I also sit on Te Kahui, the RANZCOG New Zealand Committee and Education Standards and Reaccreditation Committees
>
> Please contact me if you require any further information.
>
> Yours sincerely
>
>
>
> Celia Devenish Consultant Obstetrician & Gynaecologist
> MBBS FRCOG FRANZCOG
> *Electronically reviewed & signed*

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REPORT re 22HDC01701

Regarding whether the care provided to [Ms A] by Te Whatu Ora was reasonable in the circumstances, and why.

In particular, please comment on:

Te Whatu Ora|Te Toka Tumai Auckland

1. **The adequacy of [Ms A's] pain management whilst she was in ED.**

   Ongoing pain relief was prescribed but not given immediately. This was most likely related to the high acuity of the unit with reduced staffing levels that night. The persistent pain might however have been reviewed by the team on call had the ED staff been aware of this, and asked for Women's Health review. Vitals remained stable. The Covid positive status may have lengthened the time required to review [Ms A]. I believe that the acuity and staff shortages caused delay in providing relief due to the need to triage all needs of the patients waiting for care and pain relief. I do not believe there was a significant deviation from the expected standard of care given the circumstances.

   Given the acuity of the unit and the demand on staffing resources over the evening and night shifts I do not feel there is a deviation from the expected standard of care. The hospital records show that pain relief was given at appropriate and increasing amounts to reach a level of pain control that would be expected.

   I believe my peers would agree with this.

2. **The adequacy of oversight provided by [senior SMOs] on June 13 and 14 2022.**

   When on call the SMOs are dependent on the onsite registrars conveying information to them, for which there are clear guidelines. SMOs attend evening Handover and then are on call by phone overnight if not already on site for emergencies. They are available for advice and attendance to assist if called. I do not believe there was a deviation from the expected standard of care. I believe my peers would agree with this.

3. **The reasonableness of the three-hour delay to theatre and the 800ml of blood loss [Ms A] experienced.**

   Given the required protocols as advised by the infectious disease specialist consulted, I believe the delays in assessing theatre were inevitable. The theatres had high acuity and prioritisation of all cases waiting for theatre is a matter of course. Real risks such as the need to close theatres and staff becoming infected is a serious concern. Infections result from breaches of the Covid protocols, which are essential to avoid further compromise to surgery delivery and facilities. [Ms A's] vital observations remained normal over the time she was waiting, suggesting that there was no critical amount of blood loss which compromised her care. A blood

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transfusion was not required. It cannot be known in retrospect when the accumulated blood loss occurred, but most likely this occurred slowly over a number of hours. I do not believe there was a deviation from the expected standard of care. I believe my peers would agree with this.

4. The reasonableness of the eight-hour delay in getting a formal USS.

I believe the delay was reasonable given the workload experienced by ultrasound departments and the need for additional precautions with a Covid positive patient. The morning ward round by the surgical team at 7.30 am 14/6/23 and clinical assessment did record that the vital signs were unchanged. There were no clinical signs of patient compromise at this time, so there was no immediate urgency for intervention.

The result of the ultrasound later that morning enabled transfer back to Gynaecology for definitive surgery. Had the request been made by the Women's Health team there would have been a similar delay overnight.

The total blood loss would have occurred over at least twelve hours, and the urgency of operating needed to be balanced by the need to protect both the patient and others potentially exposed to Covid, including nursing and ultrasound staff and other patients, all working with the burden of reduced staff numbers.

5. The appropriateness of the ED triage score given to [Ms A].

The triage score on admission was 5. I believe that this was low for a pregnant woman with pain. Nevertheless the ED doctor attended [Ms A] in a time much shorter than a triage of 5, especially given the acuity of the ED and short staffing that evening. Presumably someone recognised that the score should have been a 3, and acted accordingly, as a 2.25 wait time is in accordance with a triage score of 3. [Ms A] was given 20mcg Fentanyl almost hourly starting within an hour of admission being completed and seen by ED doctor within 2hr 20 mins and referral to Women's Health Team made subsequently as per protocol. I believe there was no deviation from the expected standard of care. I believe my peers would agree with this.

6. The adequacy of the attached Te Whatu Ora policies.

The advisability for Transvaginal ultrasound to confirm early pregnancy findings could be added to these policies. I believe the Te Whatu Ora policies are otherwise adequate. I believe my peers would agree with this.

7. Any other matters in this case that you consider warrant a comment.

The availability of transvaginal probes in Emergency Depts is useful, if appropriate training is also provided to O&G trainees who should also be supervised appropriately by a senior practitioner. I believe my peers would agree with this.

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[Dr B]

1. **The reasonableness of the care provided by [Dr B] in the context of her experience and training.**

The accepted standard of care is that an ectopic cannot be excluded on a transabdominal ultrasound alone. The context of the scan was that [Dr B] was primarily on obstetric delivery room call for the night. She had been called by the less experienced registrar to perform an ultrasound because of her greater experience both clinically and in scanning pregnancy. The absence of free fluid on Transabdominal ultrasound suggests there was no rupture at this point in time. Free fluid is usually seen on a transabdominal scan if significant in amount, and if the uterus is identified. There was no vaginal probe available in ED and the poorer definition of such an ED ultrasound machine is not as clear as those high definition scanning machines found in an USS Dept. Transabdominal ultrasound uterine content findings are more challenging in a woman with a raised BMI. Although she had suggested a follow up formal scan this was not documented nor requested by Women's Health. In the event the General Surgical Reg requested an Abdominal pelvic Ultrasound to clarify the cause of the right lower quadrant pain in early pregnancy. The alternative was that the junior registrar could have called the SMO for advice and need for formal ultrasound. This would have avoided the unfortunate reassurance [Ms A] received from [Dr B] that an intrauterine pregnancy existed.

[Dr B] was supporting the junior registrar overnight, but unfortunately made the incorrect conclusion. At this point in time there was no significant free fluid as none was noted, which would have raised concerns as to its origin. Her experience and training were such that it was reasonable that she should perform such a scan, but not exclude an ectopic without performing a transvaginal scan. No TVS probes being available in ED. Therefore, arranging a transvaginal scan was a priority.

It is unclear if [Dr B] performed an examination herself as this examination had been done previously by the junior registrar. This is an appropriate examination to repeat if there has been a reasonable time lapse after the initial vaginal examination, presumably performed by the junior registrar rather than the ED doctor. The benefits of performing a pelvic examination prior to scanning include: Pelvic Examination may have confirmed cervical movement tenderness. There may also have been a change in findings including the presence of cervical motion tenderness. It is possible [Dr B] believed the junior registrar to be capable of examining patients and had just done so. Even so seniors would usually perform an examination before performing an ultrasound to help rule out causes of pain including ectopic pregnancy.

The reasons why the examination did not occur could include time restriction due to demands of the Delivery ward which [Dr B] was primarily looking after. Also, the history of shoulder tip pain may have led an experienced practitioner to consider

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an ectopic over other gynaecological conditions in pregnancy. Examination is usual prior to performing an ultrasound scan in ED. I believe the lack of clinical and pelvic examination contributed to the misdiagnosis on ultrasound and is a minor deviation from the expected standard of care. I believe the diagnosis of an intrauterine gestation provided was a moderate deviation from the expected standard of practice. I believe my peers would agree with this.

Also because no definitive high resolution transvaginal ultrasound was arranged to confirm the ED bedside scan findings at the time. Fortuitously the General surgeon team requested the ultrasound later on in the night. Such ultrasound scans are rarely performed after hours, so the timing of the ultrasound the next day would not have been different. It is likely that [Ms A's] total blood loss was increased slightly by the combined delays and due to the management of Covid risks, as discussed with infectious disease physicians.

It is not possible in retrospect to determine the time that tubal rupture and further bleeding occurred. However, the vitals were not impacted and remained within normal range. I believe the failure of the Women's Health team to arrange the follow up formal transvaginal ultrasound was a moderate deviation from the standard of care. The fact that [Ms A] was Covid test positive at his point in time also impacted the availability of beds and ability to provide ultrasound because of the risk to others. I believe my peers would agree with this. The recommendation is that all women in early pregnancy with pain have a Transvaginal Ultrasound.

2. **The appropriateness of her decision to undertake a bedside transabdominal USS (rather than transvaginal USS) in ED.**

There was no vaginal probe available in ED and the definition of ED ultrasound machines is not as good as those in an USS dept. In view of this, unless there are clear clinical signs of concern, it would be usual to request a formal TVS in a Radiology Dept where a high definition formal pelvic ultrasound scan can be performed and reported. Although [Dr B] had suggested a follow up formal scan at the time, unfortunately this was not documented in the notes, nor requested by Women's Health.

In the event the General Surgical Registrar requested an Abdominal pelvic ultrasound to clarify the cause of the right lower quadrant pain in early pregnancy. This then demonstrated a ruptured ectopic. I believe my peers would agree with this. I believe this absence of a follow up Transvaginal ultrasound scan was a moderate deviation from the expected standard of care.

3. **The failure to follow Te Whatu Ora's acute gynaecology pathway.**

Te Whatu Ora's acute Gynaecology pathway provides an orange flag for abdominal pain > 5/10 which meant the registrar or SMO and if a confirmed IUP admission to WAU and level 9 ultrasound. Covid bed availability impacted this process, though a bed was available in CDU. I believe this was a mild deviation from the expected

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standard of care because of a complicating aspect of [Ms A's] positive Covid status. I believe my peers would agree with this.

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

I believe the willingness of the senior registrar to assist the junior was commendable, but unfortunately in this case resulted in an erroneous opinion. The subsequent days being Rostered Days off after Night call most likely prevented [Dr B] from being able to easily follow up with [Ms A] at the time of her admission. She may not have been immediately aware of the outcome.

5. Recommendations to avoid similar events in the future.

I recommend that all trainees be reminded that the standard of ultrasound provision in early pregnancy, is that a Transvaginal scan be performed to confirm all early pregnancy findings, and a formal scan is advisable unless the patient is clearly unstable and requiring urgent surgery.

Celia Devenish'

The following advice was received on 21 January 2024:

'Thank you for your email and attachments containing further information and comments from [the] Quality Safety and Risk Officer, Auckland Hospital and [Dr B]. I have read these documents. I appreciate that the learning from this case has been shared.

I believe the acute gynaecology pathway for pregnancy presenting with pain, (irrespective of bleeding or not) should mention the need for TVS ultrasound to exclude ectopic gestations. The failure to accurately record the care plan [Dr B] recommended was compensated for by the Surgical team who requested a formal ultrasound. Without which the patient would not have been diagnosed so promptly.

In summary, my understanding regarding responsibility is that if a Gynecology Consultant has a patient who was seen under their care whilst on call, then that Consultant remains responsible for the plan of care and ensuring it is completed, and acting on any results of investigations, until the case passed on to another team.

If the Consultant is not told of the case or of the plan going forwards, then it remains the responsibility of the person(s) who saw the patient, and who performed the investigations unless the Consultant on call is made aware of these.

Should the plan made not be documented accurately, and therefore not completed, then the responsibility still remains of the person who made the plan.

Had this case been discussed, even at the end of the shift, with the Consultant on call, they would then have been able to ensure the formal ultrasound including TVS had been requested.

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I believe my peers would agree with this.

In summary, whilst [Dr B] offered assistance with the best of intentions, failure to ensure documentation of the plan, or check that the TVS formal ultrasound request was in place, and/or ensure the on-call Consultant was made aware, did create risk for the patient. Especially if the General Surgeons had not arranged the formal TVS ultrasound.

I acknowledge there are ameliorating factors, and that a formal ultrasound did ultimately diagnose the ectopic pregnancy.

In view of all the above I do not wish to change my advice of November 7 2023.

Kind Regards,
Celia Devenish'

The following advice was received on 19 February 2024:

'**As evidenced within the clinical notes, [Dr B] did not document her clinical findings following her examination of [Ms A] and she did not document a plan to complete a transvaginal ultrasound scan. Instead, [Dr C] documented on behalf of [Dr B] which [Dr B] said was done without her input.**

Would you consider the failure to complete documentation by [Dr B] to be a departure from the expected standard of care? And if there is a departure, how would you quantify this? (Mild, Moderate or Severe)

Thank you for your query.

In the circumstances of night cover assisting a Junior I think it is a MILD deviation.

The expectation would be that the junior Registrar also note the plan appropriately.

I believe my peers would agree.

Kind Regards

Celia Devenish'

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