Failure to refer for endoscopy
(15HDC00792, 29 June 2016)

General practitioner ~ Medical centre ~ Dysphagia ~ Weight loss ~ Endoscopy ~ Right 4(1)

A 58-year-old man had a regular general practitioner (GP) at his medical centre, but from time to time consulted another GP who was employed at the medical centre.

The man presented to the second GP with symptoms of epigastric pain (which had been present for a month), difficulty swallowing (dysphagia), increased wind, and weight loss. The GP recorded that the man's weight was 84 kilograms and that he had not been trying to lose weight. However, the GP understood that the man's weight loss was a result of lifestyle changes and was therefore not unexplained. The GP's working diagnosis was gastritis. She prescribed the man omeprazole 40 mgs and Metamide 10 mgs, and arranged blood tests (the results of which were normal).

A few weeks later, the man saw the GP for review and complained of ongoing difficulty swallowing. The GP did not weigh the man. Her plan was for the man to continue with his lifestyle changes and to return if his symptoms continued.

The man next saw the GP approximately two months later. He told the GP that he had lost a further six kilograms, felt tired and had continued difficulty swallowing. At this point, the man weighed 78 kilograms. The GP reviewed earlier clinical records and found that several years earlier the man had weighed 93 kilograms. The GP ordered repeat blood tests and a chest X-ray (all of which returned normal results), and formed a "possible plan" to refer the man for a gastroscopy (a form of endoscopy).

The GP reviewed the man again the following week. The man complained of gastric pain, burping and general discomfort, and said he felt as though food was getting stuck in his oesophagus. The man reported some weight gain. The GP did not weigh the man, but was reassured by the reported gain. The GP advised the man to take omeprazole and Metamide together regularly and to return for further review and for a possible referral for a gastroscopy if he was not better.

The man consulted his regular GP several months later. He was referred the same day for an urgent endoscopy and concurrently for a barium swallow. The next month, the man underwent an oesophagoscopy (another form of endoscopy), which revealed a signet-ring carcinoma in his lower oesophagus.

By failing to assess the man appropriately and arrange for him to be referred urgently for an endoscopy, the second GP failed to provide services to the man with reasonable care and skill and, therefore, breached Right 4(1).

The medical centre was found not to have breached the Code.

A number of recommendations were made, including that the second GP arrange for an independent GP to conduct a qualitative review of a random selection of 30 patients' consultation notes from the last 12 months and a random audit of 10 referrals to specialist secondary services the GP had instigated in the same period, and that the GP provide a written apology to the man.

The second GP was referred to the Director of Proceedings for the purpose of deciding whether proceedings should be taken. The Director brought disciplinary proceedings in the Health Practitioners Disciplinary Tribunal which resulted in a finding of professional misconduct. The GP appealed the Tribunal's finding of

professional misconduct in the High Court. The High Court dismissed the appeal and upheld the Tribunal's decision. The Director did not take HRRT proceedings against the GP.