Misdiagnosis and premature discharge of elderly woman with shortness of breath (09HDC00865, 26 March 2010)

Locum medical registrar ~ Accident and medical clinic ~ Public hospital ~ District health board ~ Shortness of breath ~ Abnormal test results ~ System for reporting abnormal results ~ Premature discharge ~ Junior doctor ~ Orientation, training, support, and supervision ~ Consultation with senior doctor ~ Open disclosure ~ Right 4(1)

A 75-year-old woman was transferred to hospital after presenting at an accident and medical clinic with shortness of breath and chest pain. On arrival at the Emergency Department, a nurse ordered blood tests, an X-ray and an electrocardiogram (ECG). The woman was also placed on a monitor to take automatic readings of her pulse, oxygen saturation levels and blood pressure. A medical registrar examined the woman, reviewed her clinical notes, chest X-ray, ECG, and partial blood test results, and reached a diagnosis of panic attack. The registrar then discharged the woman, less than two hours after her admission.

Shortly after returning home the woman stopped breathing. Attempts to resuscitate her were unsuccessful and she died. A post-mortem was inconclusive, but the most likely cause of the woman's death was coronary heart disease.

Unknown to the doctor at the time of discharge, the woman's full blood test results were available and showed an abnormal Troponin level (indicating that a heart attack may have occurred). Also unknown to the doctor, just prior to the woman leaving the hospital the automated monitor had recorded a significantly low oxygen saturation level. The DHB openly disclosed to the family the misdiagnosis and premature discharge.

It was held that the doctor's diagnosis of "panic attack", and his decision to discharge the woman when he did, without waiting for the full test results, was inappropriate and he breached Right 4(1) of the Code.

The DHB was found to have inadequately orientated, trained, supported and supervised the doctor. It was also found to have had inadequate systems for alerting doctors to abnormal test results in a timely manner. Accordingly, the DHB breached Right 4(1).