Discharge from Emergency Department with undiagnosed bowel obstruction (01HDC04138, 8 August 2002)

Public hospital ~ Medical registrar ~ Emergency medicine ~ Standard of care ~ Missed diagnosis of bowel obstruction ~ Discharge planning ~ Rights 4(1), 4(2)

A complaint was forwarded by an advocate concerning the standard of care a woman received from a medical registrar at a public hospital. The Commissioner commenced an "own initiative" investigation under section 35(2) of the Health and Disability Commissioner Act 1994. The issues investigated were that the medical registrar failed to provide services of an appropriate standard and, in particular: (1) did not adequately assess the woman's condition prior to her discharge home; and (2) did not ensure that appropriate or adequate follow-up services were in place prior to her discharge. The woman, who suffered from multiple sclerosis, lived alone at home, choosing not to accept district nursing support.

The 60-year-old woman had been referred to the hospital Emergency Department by a GP, with a referral note stating that she had been vomiting blood and suffering malaena (blood in the stools) for 36 hours. She was examined by the medical registrar and diagnosed with gastroenteritis, then discharged home two and a half hours later. She was found dead the following morning. The post-mortem report found that she died of a small bowel obstruction and pulmonary infarction. The differential diagnosis of a bowel obstruction had not been documented.

The Commissioner reasoned that:

1 subtle signs of a bowel obstruction are often the rule rather than the exception, particularly in the elderly; and
2 a medical registrar would be expected to recognise bowel obstruction of the degree identified at post-mortem.

It was held that:

1 the medical registrar breached Rights 4(1) and 4(2) by his failure to: (a) carefully examine the abdomen and document his findings; (b) recognise bowel obstruction; (c) develop a differential diagnosis; and (d) recognise his professional limitations and seek further assistance from his consultant;
2 the medical registrar did not breach Rights 4(1) and 4(2) in relation to the discharge plans, as they were appropriate for the diagnosis made, even though that diagnosis was erroneous; and
3 the District Health Board was vicariously responsible for the registrar's breaches of the Code as it had not taken such steps as were reasonably practicable to prevent the omissions by its employee.

The Commissioner recommended that the Medical Council determine whether a review of the registrar's competence was warranted.