HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Woman's rights breached when ectopic pregnancy diagnosis excluded

22HDC01701

A woman did not receive an appropriate standard of care from a senior medical registrar when her ectopic pregnancy was misdiagnosed and she went on to experience a ruptured fallopian tube, the Deputy Health and Disability Commissioner has found in a decision released today.

Rose Wall found the senior registrar breached the Code of Health and Disability Services Consumers' Rights by excluding a diagnosis of ectopic pregnancy without confirming the diagnosis with a second ultrasound, performing or requesting further clinical examinations, and not documenting ultrasound results.

"Dr B was responsible for ensuring Ms A received an appropriate standard of care. The misdiagnosis of an intrauterine pregnancy, lack of a thorough clinical examination and documentation, and plan of care, created an added risk for her. I find Dr B in breach of Right 4 (1) of the Code."

The case centres on the management of the woman's care for severe abdominal pain. She was seen by a junior registrar at the Women's Health Service (WHS) at Auckland Hospital who requested the assistance of a senior registrar from the service.

The senior registrar assumed her junior colleague had performed a physical examination and taken a verbal history, so only performed a brief abdominal examination and bedside abdominal ultrasound. However, there was no record of these actions. The woman's clinical notes ruled out ectopic pregnancy and suggested appendicitis.

Later that day, abdominal and vaginal ultrasounds confirmed a ruptured ectopic pregnancy; however, surgery was not performed until five hours after diagnosis.

Ms Wall also made an adverse comment about Health New Zealand| Te Whatu Ora Toka Tumai Auckland and the lack of clarity within its acute treatment pathway.

The senior registrar, and Health NZ Auckland, advised HDC of a range of changes made since the event, which are outlined in today's decision.

Ms Wall recommended that the registrar, and Health NZ Auckland, formally apologise to the woman. She also recommended Health NZ Auckland report back on the progress of changes it has committed to make as a result of the incident,

implement a return to work programme for WHS clinicians returning from extended leave, and update its gynaecology pathway to ensure vaginal ultrasounds are always completed for women presenting with pain, to rule out ectopic pregnancy.

Ms Wall thanked the woman for sharing her experiences, expressing her condolences and noting how distressing the events must have been.

30 September 2024

Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's 'Latest Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name group providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

Health and disability service users can now access an animated video to help them understand their health and disability service rights under the Code.

Read our latest Annual Report 2023

Learn more: Education Publications

For more information contact:

Communications team, Health and Disability Commissioner

Email: communications@hdc.org.nz, Mobile: +64 (0)27 432 6709