Treatment of gastrointestinal symptoms (06HDC11343, 27 June 2007)

Medical officer in general practice ~ Medical centre ~ Investigation and treatment ~ Gastrointestinal symptoms ~ Standard of care ~ Conflicting expert advice ~ Documentation ~ Rights 4(1), 4(2), 4(4), 6(1)

A 64-year-old man complained about the care provided by a medical officer (MO) working in general practice at a medical centre, mainly relating to two periods: March to August 2004, when he was diagnosed with duodenal ulcers, and December 2004 to August 2005, when he was found to have a cancerous tumour of the colon. The MO was not vocationally registered as a GP but was sitting examinations with the Royal New Zealand College of General Practitioners, and was being supervised.

The man was diagnosed with duodenal ulcers in October 2004, after three months of vomiting, nausea and weight loss. The key issues in relation to the MO's care during this period were whether he gave adequate consideration to the possible causes for the man's symptoms, and whether he managed the man's deteriorating condition appropriately.

In the face of conflicting expert advice, it was held that the MO did not maintain a holistic oversight of the symptoms the man was experiencing. An earlier or more urgent referral for an endoscopy could have occurred if he had carried out basic physical examinations and remained alert to alternative causes for the symptoms. His overall care of the man was not of an appropriate standard and was not provided in a manner that minimised the potential to harm or optimised the quality of the man's life, breaching Rights 4(1) and 4(4). A patient in these circumstances would expect to receive information about the risk that his medications could cause gastric irritation, together with advice on what to do if that occurred. The MO therefore breached Rights 4(1) and 6(1). There was a mix-up with his medication when he was prescribed a lower than recommended dose of omeprazole, which meant that the man received less than the recommended dose for five months until May 2005; this represented a breach of Right 4(1).

The man consulted the MO regularly between May and August 2005 with nausea, vomiting, loss of appetite and weight loss before he was finally taken to hospital by ambulance in August 2005. The key issue in 2005 is whether the MO should have referred him to hospital for investigation of these symptoms rather than continuing to treat him as a general practice patient.

It was held that a May 2005 consultation should have been followed up with a referral for an endoscopy, and physical examinations should have occurred at each consultation. The MO's care was found to be deficient over a sustained period of time, and his documentation was inadequate and, accordingly, he breached Rights 4(4) and 4(2).

The medical centre was found not directly or vicariously liable for the MO's omissions.