

Health Practitioners Disciplinary Tribunal
The Director of Proceedings v Dr S— 31 August 2006

Following a hearing in June 2006 the Health Practitioners Disciplinary Tribunal upheld a charge of professional misconduct against a general practitioner, Dr S.

Ms L had been a patient of Dr S since 1991. Of note in her past medical history was a mini-laparotomy in June 1993 for elective tubal ligation, (adhesions were noted), and a history of palpitations which from March 1994 required medication with Atenolol. This was changed to Sotalol in August 1994 after she attended hospital with an episode of supraventricular tachycardia, recurrent lower back pain after an injury in September 1993, and a history of peptic ulcers which required treatment with Ranitidine.

On 11 November 2002 Ms L consulted Dr S complaining of bloating and abdominal discomfort. She was examined and prescribed Motilium. In February, April and July 2003, Ms L visited for other unrelated matters but also complained of ongoing abdominal symptoms.

On 10 October 2003, Ms L consulted Dr S regarding her bloated stomach. She was weighed (80.5kg) and Dr S prescribed Motilium and Duromine. On 7 November 2003, Ms L attended the surgery complaining of an upper respiratory tract infection. She had lost 2.5kg. Ms L told Dr S that she was having trouble breathing and that her stomach was no smaller and she still had the same problems. Dr S did not undertake a physical examination, and a repeat prescription of Duromine was provided.

On 9 December 2003 Dr S further prescribed Sotalol, Ranitidine and Duromine following a phone call.

On 24 February 2004, when Ms L visited Dr S, she was in considerable abdominal discomfort. A repeat prescription of Duromine was given without assessment. On 11 March 2004, when Ms L presented with abdominal pain, Dr S examined Ms L, querying the possibility of a mass on the left side and he arranged an urgent scan.

Ms L went home and spent the next approximately 36 hours in pain. At 3.00am on 13 March 2004, she called a friend who took her to an after-hours clinic and from there she was taken to hospital by ambulance. She was admitted acutely. On 16 March she had a laparotomy, left salpingo-oophorectomy and removal of a 14.7 kg ovarian cyst. Her admission weight was approximately 74kg. After the operation she was 57kg.

The Tribunal, in making its finding of professional misconduct, found that the following omissions amounted to a significant departure from the standards ordinarily expected of a GP in those circumstances: failure to perform a thorough abdominal examination in October, November and February; prescription of Duromine without measuring and recording Ms L's BMI, pulse and blood pressure; and failure to make adequate enquiries about her health when he prescribed Duromine again in February. By way of penalty the defendant was censured and ordered to pay costs totalling \$22,500. A condition was imposed on the defendant's practice that he attend an educational programme at the University of Otago Executive Education Department. In a majority 3:2 decision, the Tribunal granted permanent name suppression on the basis that Dr S's privacy interests outweighed the public interest.