



Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Doctor breaches code for not ordering ECG and blood test for woman presenting with chest pain

20HDC02183

A doctor at a medical centre breached the Code of Health & Disability Services Consumer's Rights (the Code) for not ordering an ECG and blood test for a woman with chest pain.

The woman, in her eighties at the time, presented to the doctor feeling unwell. She had been vomiting and had chest pain. The doctor undertook a physical examination of the woman and diagnosed a possible viral infection and/or reflux.

The woman was taken to hospital by ambulance the following day and an ECG and blood tests showed she had suffered an ST-elevation myocardial infarction (STEMI) — a heart attack caused by complete blockage of a coronary artery.

Aged Care Commissioner Carolyn Cooper found the doctor breached Right (4)1 of the Code which gives consumers the right to have services provided with reasonable care and skill.

She was critical of the doctor for not performing an ECG to investigate a possible cardiac cause for the woman's chest pain and not recommending follow-up blood testing and/or hospital care. This resulted in a delay in the woman receiving the treatment she required.

The woman's daughter, who accompanied her to the doctor's visit, told HDC they had asked 'repeatedly' if there were any additional tests, such as an ECG, that should be carried out as they were concerned about cardiac issues. However, the doctor had told them she could not carry out tests at the medical centre because that equipment was only available at the hospital.

The doctor told HDC she did not consider it necessary to perform an ECG at that time. She said the clinic did have an ECG machine, but it did not have facilities for conducting blood tests, so patients were referred to ED or to a laboratory.

The doctor told HDC she accepts not performing an ECG was an error in judgement, and that she deeply regrets this failure in her care. Since the event, she has undertaken extensive self-directed learning on acute care situations, in particular in the area of acute coronary syndrome and older women. She has presented this case to her colleagues and it was agreed that when managing a case where a cardiac cause could not be ruled out clinically, an ECG and troponin blood tests would be required.

The woman's family told HDC that they do not wish to receive an apology from the doctor. Ms Cooper said taking into account the steps the doctor has taken since the time of events, no further recommendations are required. Sadly, the woman passed away during the course of the investigation.

25 September 2023

ENDS

Editor's notes

The full report of this case will be available on HDC's [website](#). Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name 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 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

Learn more: [Education](#)