Assessment of abdominal pain in an Emergency Department (06HDC08765, 9 October 2007)

Registrar ~ General surgeon ~ Emergency department ~ District health board ~ Assessment ~ Surgery ~ Perforation ~ Documentation ~ Rights 4(1), (2)

A 27-year-old woman, visiting New Zealand from overseas, complained about the adequacy and appropriateness of the care she received from the emergency department of a public hospital.

The woman awoke in the early hours of Sunday morning with acute abdominal pain and vomiting. She was taken to the emergency department (ED) of the local public hospital. Because she had no travel insurance, she was referred to an accident and medical centre. The GP at the centre diagnosed acute appendicitis and referred her back to the ED. She arrived back at the hospital at about 2pm and was given morphine for acute pain while awaiting assessment by the surgical registrar. The registrar was not told that morphine had been administered and, when he assessed the patient, her pain had lessened considerably. He diagnosed gastroenteritis, administered analgesia and fluid replacement, and discharged her.

After arriving home, she collapsed and was returned to the hospital by ambulance at about 6.30pm. She was again given morphine for acute pain and assessed by the same surgical registrar at about 9pm. He again failed to note that morphine had been administered. His provisional diagnoses were gastroenteritis or atypical appendicitis. After consultation with the surgical consultant on call, the patient was admitted to the ward for observation and placed third on the acute theatre list for laparoscopic surgery the following day. Two other, more urgent cases were admitted and she eventually went to theatre at 3.15pm on Monday. She had a ruptured appendix and peritonitis and suffered a stormy recovery.

It was held that the registrar breached Right 4(1) for failing to exercise reasonable care and skill in his assessments and, in particular, for failing to respond appropriately to her worsening condition, and to rethink his primary diagnosis of gastroenteritis at the second presentation. He also breached Right 4(2) by his incomplete and unclear documentation. It was held that the consultant surgeon and the DHB did not breach the Code.