
Ambulance Officers / Senior House Officer / Ambulance Service / Hospital

Report on Opinion – Case 99HDC02269

Complaint

The Commissioner received a complaint from the complainant regarding her partner's treatment from an ambulance service and a hospital. The complaint is that:

In mid-January 1999 ambulance staff from an ambulance service failed to treat the consumer with appropriate respect when attending him at his home. In addition the ambulance staff did not pass on to the hospital information provided to them about the consumer's condition by his partner, instead advising them that the consumer's condition was psychosomatic.

On the same day medical staff from the hospital failed to appropriately examine the consumer and diagnose his systemic illness, instead supplying him with painkillers and sending him home in a taxi still in pain and not knowing what was wrong with him. The consumer died at home later that day.

**Investigation
Process**

The complaint was received by the Commissioner on 24 February 1999, and an investigation was commenced on 31 March 1999. Information was obtained from the following people:

Complainant/Consumer's partner
Chief Ambulance Officer, Ambulance Service
First Ambulance Officer, Ambulance Service
Second Ambulance Officer, Ambulance Service
Clinical Head of Emergency Department, Public Hospital
Senior House Officer, Public Hospital
Manager, Taxi Service
Driver, Taxi Service

Medical notes, correspondence and copies of patient advice were obtained from both the ambulance service and the hospital. The Commissioner also received advice from an independent emergency medicine specialist.

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**Information
Gathered
During
Investigation**

One morning in mid-January 1999 the consumer awoke with bad back pain. This pain intensified during the course of the day. At 6.00pm the consumer took Voltaren to ease the pain. At around 10.00pm the consumer began vomiting and complained to his partner that he was feeling hot. The consumer's feverish symptoms continued throughout the night fluctuating between extreme heat and extreme cold. The consumer lost control of his bowels and asked his partner to place a towel under him. The following day at 3.24am the consumer's partner rang an ambulance at the consumer's request.

Ambulance services

At 3.29am an ambulance from an ambulance service arrived with an ambulance officer at the wheel and a second ambulance officer, team leader and paramedic, in attendance. The consumer's partner met the ambulance staff at the door and showed them to the living room where the consumer was lying on the floor naked with a towel under him.

The consumer's partner stated she informed the second ambulance officer that the consumer had experienced bouts of vomiting from 10.00pm and that he had been suffering from loss of bowel control and extreme fevers.

The second ambulance officer stated that on entering the living room he asked the consumer how he could be of assistance and the consumer replied that he needed some drugs. The ambulance officer reported that the consumer appeared pale with cool dry skin, and a radial pulse which felt strong, regular and was at the rate of 76. The ambulance officer covered the consumer with a blanket. The consumer informed him that he had back pain and had vomited after taking Voltaren. The ambulance officer does not recall being informed of the consumer's incontinence.

The second ambulance officer stated he did not consider the consumer presented as a patient with back pain normally would. For example, while taking the history the consumer would prop himself up on his elbows, lean toward him and then slump back down. The ambulance officer felt that the consumer was having difficulty in getting comfortable but did not appear to be in pain. He noted the consumer was lucid and alert but stated that he seemed to avoid answering questions.

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**Information
Gathered
During
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*continued***

The second ambulance officer stated that his problems in extracting a history from the consumer were compounded by the consumer's partner responding to the questions made to the consumer. The consumer's partner stated that she answered for the consumer because he requested that she do so.

The ambulance officer advised the Commissioner that it became increasingly difficult to communicate with the consumer and he wondered whether there might have been an emotional element to the problem which prevented the consumer from speaking freely. He therefore asked the consumer's partner to leave the room for a couple of minutes. The ambulance officer reported that it is common practice to ask friends and family to leave the room when ambulance staff experience difficulty in establishing a rapport with a consumer.

However, the ambulance officer stated that he was unable to obtain further information from the consumer before the consumer's partner returned to the room and therefore made the decision to take the consumer to the Accident and Emergency Department at a nearby hospital.

The consumer's partner fetched some clothing and the consumer was helped to dress. The second ambulance officer was concerned about using a carry chair due to the consumer's size, restlessness and the slippery path. The ambulance officer asked the consumer whether he would be able to walk to the ambulance and the consumer stated he could. At this point the consumer dry retched into a bucket. The consumer walked to the ambulance with both ambulance officers assisting him. The ambulance staff had spent 11 minutes at the scene.

Once in the ambulance the consumer was placed on the cot and covered in blankets. The second ambulance officer reported that with the heater on the consumer began to appear better.

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**Information
Gathered
During
Investigation
*continued***

On arrival at the hospital the first ambulance officer opened the back doors. The consumer stated he felt sick. The second ambulance officer turned to get a vomit bowl and reported that while he was doing this the consumer twisted himself off the cot and onto the floor. He then crawled to the back of the ambulance and dry retched once more. The consumer then stood and climbed onto the stretcher fetched by the first ambulance officer. The second ambulance officer states these manoeuvres reinforced his suspicion that back pain was not the consumer's chief problem.

At 3.50am the ambulance officers wheeled the patient into the Accident and Emergency Department and spoke to two staff nurses.

The Ambulance Officer's Patient Report Form was completed by the second ambulance officer, documenting the following:

Chief Complaint: "*Back pain/?Psychosomatic*"

History: "*Pt woke this a.m. with central back pain around the area of his coccyx, denies any injury. As the day progressed Pt c/o feverishness and vomiting. Took Voltaren at 1500 hrs. Began vomiting at 2200, o/a Pt sleeping on floor naked in a cold room, o/e lucid, alert. Difficult to get a straight answer. Cool, pale skin.*

? Vomited in our presence. Pt is making the most of the situation (hard to tell if genuine)."

Public Hospital

The Clinical Head of the Emergency Department (ED) at the hospital stated that staff were informed by the ambulance officers that the consumer had been lying naked on the floor and had vomited after taking some Voltaren.

A triage assessment was conducted and the consumer's pulse was recorded at 91, his blood pressure at 117/69 and temperature 36.1°C. The consumer reported he had been swimming earlier that day and that the warm water had helped to ease the pain.

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**Information
Gathered
During
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continued**

The clinical head of the Emergency Department stated:

“According to the ambulance record, the officers had some doubts about the severity of some of his symptoms The nurses involved are quite clear that they went on to make their own assessment of his situation.”

At 4.00am the senior house officer saw the consumer. She took a history from the consumer who stated he had had back pain for the previous two days and had taken a Voltaren tablet at 6.00pm with some relief of the pain. He had vomited once at 10.00pm and thought that the Voltaren had upset his stomach. The back pain had become worse and he had called an ambulance. The senior house officer recalled the consumer asking for an injection for the pain. The senior house officer stated that the consumer said he had suffered back pain before and thought he had aggravated it by doing some heavy lifting a few days previously. She further reported that the consumer denied any fever, bowel or urinary disturbance, and said that he had no other medical problems, was not on any regular medication and had no allergies.

On examining the consumer, the senior house officer made the following observations:

“On examination, [the consumer] appeared alert and oriented, although he was in obvious discomfort By that time he was sitting on the bed so I proceeded to palpate his back, he again pointed to the sacroiliac region to indicate the location of the pain. There was no specific point of tenderness in the midline along his lumbosacral spine. I noticed muscular spasms on both sides of the para vertebral columns. His renal angles were non tender in percussion, I then asked him to lie flat and examined his abdomen, which was soft and non-tender.

I then examined his legs which had good range of movements and he can fully straight leg raise on both sides [sic]. The tone, power and reflexes were all normal in the lower limbs. Light touch sensation on both legs was normal.”

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**Information
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The senior house officer's working diagnosis was muscular strain and spasms of the back. She ordered Voltaren 75mg intramuscularly and Norflex 100mg orally which was documented as administered at 4.00am. The senior house officer also ordered nursing staff to collect a urine specimen.

The consumer remained in view of staff. He appeared restless and changed position from lying to standing frequently. The senior house officer felt this was in keeping with acute back strain.

The consumer reported to nursing staff that the Voltaren injection had not helped and appeared restless. The senior house officer ordered pethidine 100mg together with Maxolon 10mg intramuscularly and a staff member documented on the medication chart that pethidine and Maxolon were administered. After about one hour, nursing staff advised that the consumer appeared much better.

There is some discrepancy as to the timing of the narcotic and anti-emetic injections. A staff nurse documented that the narcotic and anti-emetic injections were administered at 6.35am. The senior house officer recalled waiting around 30-45 minutes after giving the consumer Voltaren before administering pethidine, which would make the time of injection about 5.35am and not 6.35am. In response to my provisional opinion the senior house officer stated that the consumer was administered pethidine between 5.30am and 5.35am and that he remained in the cubicle for approximately one hour after this.

During the period between the administration of pethidine and the consumer's discharge, the senior house officer saw the consumer walk out of the cubicle to get a drink of water. The senior house officer reported that the consumer said to her that while the pain had improved he could still feel some pain in his back. The senior house officer asked the consumer whether he felt well enough to go home and the consumer agreed and was advised to take regular Voltaren and paracetamol and to take some time off work for bed rest. A medical certificate for work was offered and declined.

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**Information
Gathered
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Investigation
*continued***

A staff nurse phoned the consumer's partner at approximately 6.30am to explain that the consumer would be coming home by taxi, that a diagnosis of acute back strain had been made and that he had been given pethidine which might make him a bit woozy. The consumer's partner stated she was also informed that the consumer "*was just not handling the pain*". Records from a taxi service indicate that a taxi was called for the consumer at 6.34am.

With regard to the lack of laboratory testing, the senior house officer stated:

"It is not routine to perform any laboratory tests on someone who presents with back pain, especially if they are not elderly or have no previous health problems, and if the history suggests a mechanical back pain. Furthermore, I was not aware that [the consumer] had swinging fever, and the patient himself had denied fever when questioned. I did request for a urine specimen but I was told by the nurses that [the consumer] was unable to produce any urine specimen during the time he was in the department."

The consumer was able to walk to the taxi himself. When he arrived home his partner reported that he could not get out of the taxi himself and had to drop onto all fours on the grass verge outside. The taxi driver recalls the consumer as being "*... a frail, old man who needed help to get inside*". With his partner's help the consumer was able to get into the house and upstairs. He collapsed at the top of the stairs and requested a bath. His partner ran and helped him. At this point the consumer's partner observed he was not a good colour and was purplish around the mouth. She questioned the consumer about his treatment at the hospital and he replied that the hospital had just "*dismissed*" him.

The consumer's partner went downstairs to make him a cup of tea. Sometime afterwards she heard the consumer cry out and returned to find him inside a bedroom gasping for breath and asking for the windows to be opened. His face was purple and he had lost control of his bowels. The consumer's partner ran downstairs and called an ambulance at 8.50am.

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**Information
Gathered
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*continued***

On returning upstairs the consumer's partner found that the consumer had dragged himself towards the bathroom and had collapsed. There was a bloody fluid bubbling out of his nose and mouth and his eyes had rolled back. The consumer's partner first ran to her neighbours for help and then began cardio-pulmonary resuscitation (CPR). On the ambulance's arrival at 8.58am she continued CPR with the assistance of an ambulance officer. The consumer was not revived.

The pathology report concluded that the consumer died of septicaemia due to Group A Streptococcus, and that “[t]he portal of entry cannot be determined with certainty but may have been the wound noted on the left forearm”.

**Independent
Advice to
Commissioner**

The Commissioner received the following advice from an independent emergency medicine specialist.

The ambulance officer's assessment and report

“[The second ambulance officer's] comments on the patient report form were inappropriate. It is likely that the ambulance officer's pre-formed opinion that [the consumer] was 'making the most of it', interfered with his ability to consider the various abnormal features of [the consumer's] presentation. It also may have interfered in the officer's ability to carefully consider all of the issues in a logical professional manner. It may have contributed to the officer playing down or negating the information provided to them by [the consumer's partner] – information that was vital in providing clues confirming the systemic nature of the problem.

The officers undertook a targeted and general overview of [the consumer]. However, it is interesting that as he was naked in the room that neither officer was able to see the large necrotic lesion on the inner aspect of his left forearm. Additionally, [the consumer's partner] indicated that she had placed a towel under [the consumer] at his request because he had been incontinent. There is no mention of this in the Officer's notes.”

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**Independent
Advice to
Commissioner
continued**

The actions of the Emergency Department staff

- “1. [The consumer’s] back pain and his manifestation of it were not typical of someone suffering from acute mechanical back injury. He presented with classical ‘viscerogenic’ pain. He was constantly moving, turning, writhing and standing and lying according to all of the professional observers involved in his case. This pattern is much more typical of the patient presenting with renal colic or gallbladder colic or pancreatitis. As a consequence, it is highly likely that the pain [the consumer] was experiencing was due to referred pain from his pancreas, liver, spleen and adrenals – all found to be congested at autopsy within hours of his ED visit.*

- 2. It is difficult to understand how, if careful examination of his abdomen was performed some tenderness or guarding – particularly over his pancreas, liver and spleen, was not evident. It is also highly probably that bowel sounds would have been absent on auscultation.*

- 3. [The senior house officer] failed to see, or mention, the 50mm black lesion on the inner aspect of his left forearm mentioned by the pathologist. Given that she had missed this lesion, it is highly likely that she did not undertake a general physical review as part of her examination. While ED histories and physical exams must, by necessity, be targeted to the main complaint, it is good practice in cases where significant pathology needs to be excluded, to do a verbal quick systems review along with a quick general physical review.*

- 4. The timeframe for [the senior house officer] to undertake her history, perform the physical examination, rule out other serious possibilities and execute a working diagnosis and a therapeutic or management plan is not compatible with the times recorded in the patient chart.*

- 5. As mentioned previously, mechanical low back pain is a diagnosis of exclusion and should only be considered when all other serious possibilities have been ruled out.*

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**Independent
Advice to
Commissioner
continued**

6. [The consumer] was observed by nursing and medical personnel to have not responded to the initial analgesia. At this point, the standard requires that he be re-examined. Narcotic analgesia in these circumstances – in particular – long-acting medications such as Pethidine are not indicated.
7. A prudent medical officer would have re-examined [the consumer] following the use of a narcotic analgesic particularly in circumstances where the patient reports the pain only to be blunted. This would be a necessity for patients who are being considered for discharge.
8. The nursing staff did not keep an observation record and did not repeat the patient's vital signs despite the fact that they had to administer systemic narcotic analgesia for pain relief. Also there is no record as to the reason for not having obtained the urinalysis or any questions by [the senior house officer] as to the outcome of the test or a request for some alternative.”

Contributing factors

“I am of the opinion that there were many contributory factors to the clinical staff in the ED not paying due and appropriate attention to [the consumer's] complaint. One of these factors would have related to the ambulance officer's opinions and attitude. Even though the staff deny this had an effect, it is likely they leapt to the opinion that [the consumer] was over-reacting. I have no doubt that they believed that he believed he was in serious pain – however, it is likely that they also failed to remember the ‘great masquerader’ [i.e. that other serious conditions can produce similar symptoms to those the consumer was experiencing] and thus did not pay full attention to correctly ascertaining the cause of his pain.”

Conclusion

“The Emergency Department Staff failed to treat acute low back pain as a diagnosis of exclusion. [The senior house officer] did not appear to have performed an appropriate general systems review of [the consumer].

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**Independent
Advice to
Commissioner
continued**

It has been noted that [the senior house officer's] diagnosis and treatment was not appropriate given [the consumer's] symptoms. He was not exhibiting the physical features of a patient with mechanical low back injury. He was exhibiting the features of a patient suffering from a viscerogenic cause of low back pain.

The Group A Streptococcal Toxic Shock Syndrome which [the consumer] was suffering from, had most likely been slowly developing over a number of days prior to his presentation. This is a very rare and uncommon presentation of a systemic infection and not a differential diagnosis many doctors would have considered. By the time he presented to the Emergency Department at 0350 hours [in mid-] January 1999, he was less than five hours away from the acute manifestations of the illness that precipitated his death from GAS TTS [Group A Streptococcus Toxic Shock Syndrome]. There is nothing the ambulance officer, the Hospital Emergency Department staff or any other medical staff could have done, in my opinion, to save his life.”

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Response to Provisional Opinion

In response to my provisional opinion the senior house officer stated:

“Thank you for the opportunity to comment on your provisional opinion. I feel very badly about this matter and take very seriously the failures and shortcomings that have been attributed to me. I will think very carefully about these and I hope I will be a better doctor for them.

In a way, I feel rather hard done by because this patient's presentation was not unusual and pointed to back pain. As a 27 year old house officer, I had had some experiences with back pain cases and this one fitted in to this category. The fact that he had got some relief in a swimming pool a short time before was a pointer to mechanical back pain. I did not get from him a picture of fevers or incontinence. I asked him about bowel and urinary symptoms and noted that he had no problems either bowel or urinary. I did not know at the time and was not told that just before the ambulance came he was incontinent of his bowels. I only learned this from the complaint letter to the hospital. The patient was able to give a history to me and did not appear unable to give adequate history for me to make a reasonable diagnosis.

It seems that the timing issue regarding pethidine requires some clarification. It appears in the notes signed by the nursing staff that pethidine was given at 6.35am. The time out was 6.30am. The taxi was called at 6.34am. My clear recollection is that pethidine was given an hour before he was discharged – between 5.30am and 5.35am. It is nursing and department policy that no patient be discharged within an hour of the giving of pethidine. I was told that [the consumer] had been given the pethidine by nurses at a time I was examining another patient. I subsequently saw [the consumer] and spoke to him before he was discharged.

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Report on Opinion – Case 99HDC02269, continued

**Response to
Provisional
Opinion
continued**

I agree my notes are inadequate and that I should have set out my reasons for giving the pethidine and noted that condition [the consumer] was in when he was discharged. I should also have added comment about my discussions with him concerning return to the general practitioner if he deteriorated and the offering of a medical certificate. I did indeed intend completing the notes but these were uplifted by the clerical staff at 7.00am before I got to them. As soon as [the consumer] was discharged I had to see other patients and was involved in their treatment, and it was too late to get access to the notes before the clerical staff took them. Granted I could have completed another sheet of paper and had those forwarded to the filing clerk for insertion with the notes.

I have always had good references from my supervisors and this is the first time my clinical competency has been questioned. I have already studied the diagnosis and treatment of acute low back pain as you recommend following this incident and, of course, am willing to accept your opinion in this regard. Likewise, I am prepared to undertake a peer review of my note-taking.

This has been a bad experience for me and I have learned a great deal from it.”

**Code of Health
and Disability
Services
Consumers’
Rights**

RIGHT 4

Right to Services of an Appropriate Standard

- 1) *Every consumer has the right to have services provided with reasonable care and skill.*
- 2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*
- 5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

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Other Relevant Standards **The Ambulance Services' Operations Procedure**

Patient Report Completion and Auditing

1.1 It is the responsibility of the senior Ambulance Officer administering patient care, to ensure that a complete and accurate Patient Report Form is available at the receiving hospital or doctor's surgery where follow-up care is administered.

...

Emergency Department Orthopaedic Handbook – HHS

Low Back Pain

Examination

- *Standing if possible and record posture deformity, scars and range of movement*
- *Lying prone. Localised tenderness. Wasting of legs. Femoral stretch test.*
- *Lying on back. Abdominal palpation. Straight leg raising, bowstring. Reflexes, power and sensation. Range, hips and ankles.*
- *Rectal examination. Attention to tone and sensation in the perianal saddle area.*

Opinion: Breach – Second Ambulance Officer

In my opinion the second ambulance officer breached Rights 4(2) and 4(5) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)

The second ambulance officer did not provide services that complied with professional standards for an ambulance officer. I am advised that the role of an ambulance officer is to ascertain the nature of the patient's problems, assess their vital signs, provide some early support for the patient and determine the need for further care and disposition.

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**Ambulance Officers / Senior House Officer /
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Report on Opinion – Case 99HDC02269, continued

**Opinion:
Breach
Second
Ambulance
Officer
*continued***

The second ambulance officer acted inappropriately in forming an early opinion that the consumer's condition was psychosomatic. In assuming the consumer's problem was psychosomatic, the ambulance officer did not pay enough attention to other signs and symptoms that the consumer's partner mentioned at the time. I consider this interfered with his ability to assess the consumer in an objective and professional manner. Further, in recording his subjective judgement on the patient report form, the ambulance officer may have contributed to medical and nursing staff providing the consumer with less than satisfactory treatment.

For these reasons, in my opinion the second ambulance officer breached Right 4(2).

Right 4(5)

The second ambulance officer did not ensure continuity of care for the consumer on arrival at the hospital Emergency Department in the handover to Emergency Department staff. Staff were not sufficiently informed of the consumer's clinical signs and symptoms such as his hypothermia, his low blood pressure, his agitation and confusion. In my view the second ambulance officer did not make adequate reference to these symptoms on the Ambulance Officer's Patient Report Form. Nor did he verbally inform staff at the Emergency Department of these observations. The ambulance officer's failure to do so meant that the staff at the Emergency Department were not supplied with information that may have assisted in diagnosing the systemic nature of the consumer's condition.

For these reasons, in my opinion the second ambulance officer breached Right 4(5).

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Report on Opinion – Case 99HDC02269, continued

**Opinion:
Breach –
Senior House
Officer**

In my opinion, the senior house officer failed properly to examine, diagnose and treat the consumer. I accept my advisor's view that the consumer's presentation was not typical of someone suffering from acute mechanical back pain. His presentation was more typical of someone suffering from a viscerogenic cause of low back pain (pain caused by inflammation/pathology within organs).

The senior house officer's examination appears to have been brief and inadequate. The senior house officer targeted her examination to the consumer's main complaint (his back) and failed to undertake a systems review and general physical review. Given the atypical nature of the consumer's presentation, such an examination would have been appropriate.

The senior house officer also failed to obtain a urinalysis, despite the fact that the consumer's presentation resembled that of a person with acute renal colic. I do not accept that the reason for not testing the urine was because the consumer could not produce a specimen. This in itself could point to further pathology such as dehydration or renal dysfunction. The senior house officer's examination did not demonstrate the exclusion of other possible causes for the consumer's back pain and there was no record in the notes (besides back pain) to indicate what problems or diagnoses the senior house officer considered and eliminated.

I also note that the consumer did not respond to the initial analgesia. I am advised that a consumer who receives pain relief while in the Emergency Department should be reassessed prior to discharge, especially if requiring a long-acting narcotic for pain. The senior house officer failed to re-examine the consumer before his discharge. The administration of narcotic analgesia, in particular pethidine, which is a long acting medication, is not indicated for Emergency Department management of problems. Given the consumer's clinical signs and symptoms, I consider that it would have been appropriate to keep the consumer in hospital for further observation and monitoring of his condition. The senior house officer was too hasty in discharging the consumer that morning, especially if the Emergency Department notes are correct in stating that the pethidine was administered at the same time the consumer was discharged.

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Opinion:
Breach –
Senior House
Officer
continued

In all the circumstances, in my opinion the senior house officer breached Right 4(1) in failing to provide services in the Emergency Department with reasonable care and skill.

Opinion:
No Breach –
First
Ambulance
Officer

In my opinion the first ambulance officer did not breach the Code of Health and Disability Services Consumers' Rights. He acted as ambulance driver and provided no treatment to the consumer beyond assisting the second ambulance officer in moving him when required.

Opinion:
No Breach –
Ambulance
Service

Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code.

The second ambulance officer was an employee of an ambulance service. However, in the circumstances the ambulance service had taken such steps as were reasonably practicable to ensure that ambulance officers completed Patient Report Forms accurately. Accordingly the ambulance service is excused from vicarious liability for the second ambulance officer's breach of Rights 4(2) and 4(5).

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Opinion: Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code.

**No Breach –
Public Hospital**

The senior house officer was an employee of the hospital. However, in the circumstances the hospital had taken such steps as were reasonably practicable to ensure the senior house officer properly examined, diagnosed and treated the consumer. Accordingly the hospital is excused from vicarious liability for the senior house officer's breach of Right 4(1).

**Actions:
Second
Ambulance
Officer**

I recommend that the second ambulance officer:

- Apologises in writing to the consumer's partner for breaching the Code of Rights. This letter will be forwarded to the Commissioner who will forward it to the consumer's partner.
- Refrains from making and documenting any personal and subjective judgements while assessing patients in future.

**Actions:
Senior House
Officer**

I recommend that the senior house officer:

- Studies the diagnosis and treatment of acute low back pain and in future approaches diagnosis in a systematic manner, eliminating serious systemic illnesses before diagnosing mechanical back pain.
 - Undertakes a peer review of her note-taking, with the goal of improving the quality of information recorded in the clinical notes.
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**Ambulance Officers / Senior House Officer /
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Report on Opinion – Case 99HDC02269, continued

- Other Actions**
- A copy of this opinion will be sent to the Medical Council of New Zealand with the recommendation that a competence review of the senior house officer be undertaken.

 - A copy with identifying features removed will also be sent to the New Zealand Ambulance Board and to each Hospital and Health Service (for the attention of the Emergency Department), for educational purposes.
-