Registrar, Emergency Medicine

Public Hospital

A Report by the

Health and Disability Commissioner

(Case 03/HDC10460)

Parties involved

Mr A (deceased)	Consumer
Mrs A	Complainant, consumer's wife
Dr C	Provider / Registrar, Emergency Medicine
Dr D	Clinical Director, Emergency Department, a public hospital
Ms E	Triage Nurse, Emergency Department, a public hospital
Ms F	Nurse, Emergency Department, a public hospital
A Public Hospital	Provider

Complaint

On 14 July 2003 the Commissioner received a complaint from Mrs A via a Health and Disability Advocate, about services her husband, Mr A, received at a public hospital Emergency Department in October 2002. The complaint was summarised as follows:

Dr C did not provide Mr A with services of an appropriate standard. In particular, Dr C did not:

- *conduct an adequate physical examination*
- *make adequate enquiry into Mr A's health history and history of the presenting symptoms*
- *consider an alternative explanation for Mr A's presenting symptoms*
- *follow up blood results before discharging Mr A*
- *review Mr A before discharging him.*

An investigation was commenced on 11 September 2003.

Information reviewed

- Information from Mrs A, Dr C, the Coroner, and the public hospital.
- Mr A's records from the public hospital.
- Independent expert advice was obtained from Dr Scott Pearson, specialist emergency physician.

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Information gathered during investigation

Background

At about 5pm, Mr A, a 75-year-old retired pharmacist, came home from a club and informed his wife, Mrs A, that he felt unwell. Mrs A said that her husband felt "a sudden band of pain around his body, just above the waist, like a tight wide belt". He was restless and could not make himself comfortable.

Mrs A advised me that at about 8.15pm her husband noticed blood in his faeces (he had a history of ulcerative colitis) and was "retching every half hour". She telephoned their general practitioner but, because it was after-hours, the call was transferred to the medical centre in a nearby town. A doctor at the centre advised hospital assessment and arranged an ambulance transfer. The ambulance arrived at the Mr and Mrs A's home at 9.10pm. The ambulance report stated:

> "Has had lower back pain gradually increasing since 5pm. 10/10 [pain score]. Dull pain that gets sharper on movement. Requested backup for analgesia as entonox not effective. Has not taken prednisone today… Hx [history of] PR [rectal] bleed tonight – bright blood. Appears minor. Has had previously with his ulcerative colitis. Pain ↑ with touch. Lower L) back."

A provisional diagnosis of "lower back pain" was made by the ambulance officer who assessed Mr A.

Presentation at hospital

Mr A arrived at the public hospital Emergency Department at 9.47pm. According to Ms E, the triage nurse, he was seen by her within five minutes of arrival. Ms E stated:

> "When I carry out a Triage assessment the first thing I do is ask the patient what brought him or her into hospital. He told me he had lower back pain and said the pain was getting worse since 1700 hours.
>
> I then assessed [Mr A] by listening to the ambulance paramedic who described back pain and asking [Mr A] precisely where the pain was and how long had he felt it.
>
> I asked him if he had chest pain. [Mr A] did not have any chest pain. His breathing was not laboured. There was no shortness of breath. I made these assessments to exclude the possibility of pulmonary embolism or myocardial infarction.
>
> I took his blood pressure which was 92/52 on his right arm, and 105/55 on his left arm. I took the pulse which was 97 and his temperature which 36.6ºC. His oxygen score was 100% on air and his Glasgow coma score was 15/15.
>
> [Mr A] answered all questions himself. He did not appear distressed at this time.

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At the completion of my assessment I assigned him [a] Triage Code of 4. Under our triage protocols a score of 4 indicated a semi urgent description of urgency with a waiting time of under one hour."

In the notes, Ms E recorded "Lower back pain. Not distressed but unable to get comfortable". Mrs A stated that her husband could not lie down – he sat in a chair and "leaned forward, with his head on his arms on the bed".

Mrs A stated that at about 10.30pm another nurse came and took blood samples for testing (notes record that the blood was taken at 11.15pm). At 10.40pm another nurse brought codeine, Panadol, diazepam and Voltaren tablets for her husband, who initially refused to take the Voltaren because of his ulcerative colitis. The nurse left the Voltaren on the basin in case Mr A changed his mind.

On the assessment form, for 10.40pm, the "primary" nurse recorded:

"Feeling [nauseous]. Declining antiemetic. Declined Voltaren [due to] ulcerative colitis. Given other pain relief. Uncomfortable, moving freely on chair, leaning on back."

Mrs A said that ten minutes after the nurse left, her husband took the Voltaren. She also said that the nurse who brought the medications did not return so would not have known whether or not her husband had taken the Voltaren. She said that Dr C came to see them at about 11.20pm.

Assessment by Dr C

Dr C stated that on the evening Mr A presented he was working as a registrar in the Emergency Department. He came on duty at 10pm and was advised of Mr A's presence about 10.45pm. He was told by a nurse that Mr A had come with back pain and that he was uncomfortable and unsettled. Accordingly he prescribed pain relief (Panadol and codeine), an anti-inflammatory (Voltaren) and diazepam (as a muscle relaxant).

Notes record that Mr A was given the diazepam, Panadol and codeine at 10.45pm.

Dr C stated that a short time later the nurse returned and told him that Mr A informed her that he could not take the Voltaren because he had ulcerative colitis. As a result, at about 11.15pm, Dr C went to see Mr A and discussed the medication and his concern about it. En route the nurse informed him that Mr A did not want to lie down in bed and had told her that it made his pain worse. He wanted to stay in the chair. Dr C stated:

"I had an initial discussion with [Mr A] about the Voltaren and his concerns regarding ulcerative colitis. We agreed that although it was not contra-indicated for ulcerative colitis, we would wait and see if the other medication he had taken worked to give him pain relief. If it did not we would then review the situation."

Mrs A advised me that Dr C saw her husband on only one occasion and that no discussion took place about him not taking the Voltaren, as her husband had already taken it.

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Clinical examination

Dr C stated:

> "As I was now with [Mr A], I decided to do an initial assessment on him with him sitting up. My usual practice is to do an examination on a patient lying down. I did not insist on him lying down at that stage, because I was happy to do an initial examination with him seated. My thinking at that stage was then to wait for the pain killers to work, at which time I would come back and do a more thorough physical examination."

According to Mrs A, Dr C came to see her husband at about 11.20pm. She described the contact as follows:

> "'Hullo, [Mr A], now where is the pain?' [Mr A] indicated by pointing at his right side back, just below the waist, where it seemed to have now localised. The doctor found the place and pressed it, and [Mr A] groaned.
>
> Doctor – 'When did it start?'
>
> [Mr A] – 'Five o'clock.'
>
> Doctor – 'Does it hurt all the time?'
>
> By this time [Mr A] is really woozy and slurring his words (the medication?), and said 'When I move.'
>
> Doctor – 'How much blood was in the faeces?'
>
> [Mr A] – 'Not much.'
>
> Doctor – 'Are you still vomiting?'
>
> [Mr A] – 'Nothing left.'
>
> There was no further examination of any kind, and no further questions.
>
> Doctor – 'It is a muscular condition. When the pills have worked and you feel better, you can go home. I'll give you a prescription for the pain.'
>
> The doctor left."

Dr C's recollection of the clinical examination was more detailed. In a letter dated 20 May 2003 to Dr D, the Director of Emergency Medicine at the public hospital, Dr C stated:

> "I performed as thorough an examination as [Mr A] would allow. It is usual practice to examine a patient lying flat on an examination table. However I did not insist on [Mr A] lying down as the nurses had already told me that [Mr A] was unable to get into bed. They had stated to me that this was aggravating the pain and that he was most comfortable sitting in a chair.

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> During the course of the examination I found [Mr A] was comfortable. The examination of his cardiovascular system revealed normal heart sounds with a pulse rate of 87. His blood pressure was recorded by the triage nurse as 92/52 mmHg on the right arm and 105/55 mmHg on the left arm.
>
> His respiratory system was normal with a clear chest. His abdomen was soft and non tender and felt normal. He had pinpoint tenderness over the left lumbar region which was reproducible. I have documented my clinical examination in the notes. The findings were consistent with musculoskeletal pain.
>
> The blood pressure was considered and not completely ignored as stated. However it was an isolated finding in an otherwise normal clinical examination, there were no other signs of Hypovolaemia, and there was a reasonable other explanation for his pain."

In the clinical notes Dr C recorded:

> "Back pain 4/24 [four hours' duration]. Sudden onset of back pain in the left lumbar area. Localised tenderness and non-radiating. No other associated symptoms. No previous Hx [history of] back pain. PM Hx [past medical history of] ulcerative colitis. Nil else of note. Medication prednisone PRN [as required]. O/E [on examination] Pt [patient] comfortable. Pulse 97 [per minute]."

Dr C made other abbreviated entries, which he said meant that Mr A was not jaundiced, anaemic or cyanosed, he had no clubbing, and his jugular venous pressure was normal. The cardiovascular system was normal, as was the respiratory system with regular breath sounds. The abdomen was non-tender. In the back there was "localised tenderness over the left lumbar region. Pinpoint and reproducible". There was no spinal tenderness. A diagnosis of "musculoskeletal pain" was made.

Dr C advised me that his notes were recorded shortly after he examined Mr A.

Hospital notes record that bloods for biochemistry (urea and electrolytes) and full blood count were taken at 11.15pm.

In response to Mrs A's allegation that his examination of her husband was "cursory", Dr C acknowledged that he did not perform a full examination. He stated:

> "I did not go in intending to do a full examination for two reasons, one there were other patients … more serious waiting and the second thing is I just wanted to clarify the issues stated by the nurse. And the other reason was that [Mr A] wasn't in pain and he was sitting down … therefore a full examination would have taken a lot more time than I could spare at the moment so I just wanted to make sure [Mr A] was alright initially and I could do a preliminary examination to make sure there wasn't anything going wrong seriously and then come back and do a review."

Dr C had no recollection of being told that Mr A had "a band of tight pain".

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Mrs A has no recollection of Dr C touching her husband's abdomen or listening to his chest. She also has no recollection of Dr C enquiring about her husband's past medical history other than ulcerative colitis and the medications he was on. Mrs A recalled nurses and not Dr C asking those questions.

Management plan
Having made the diagnosis of musculoskeletal pain, in his notes Dr C recorded:

> "Plan (1) Panadol / Voltaren and Diazepam [and] Codeine. (2) Discharge when pain free."

In a statement to the Coroner, Dr C stated:

> "My plan was therefore to wait to see if [Mr A] became pain free as a result of the pain killers, to await the results of his blood tests and if these were satisfactory and if he was pain free, to discharge him. I told [Mr and Mrs A] that this was the plan. It would be consistent with my usual practice to ask [Mr and Mrs A] to wait until the blood results were available."

In a letter to Dr D dated 20 May 2003, Dr C also stated:

> "I cannot recall whether I asked him to wait for the blood results to come through. The results were unavailable at the time of examination."

Mrs A advised me:

> "We sat for about twenty minutes, and decided we may as well leave. We trusted the doctor's judgment, and thought [Mr A] might be more comfortable at home. We discussed the blood tests, wondering if we should wait for the results, but decided the doctor would have told us if we should wait, and he would surely let us know, if they found anything wrong."

In a statement to the Coroner, Dr C stated:

> "Some time later [after the examination] a nurse [Ms F] came to see me to tell me that [Mr A] wanted to go home. I was unable to attend upon him because I was busy with another patient. I said that I would prefer him to wait until the blood test results were available but if the [Mr and Mrs A] insisted on going they could. I remember that my clear understanding was that [Mr A] was now pain free. I had checked shortly before this to see if the blood results were available, but they were not. However I was not overly concerned about this as [Mr A's] presentation was stable, consistent with musculo-skeletal pain and I did intend to follow up the test results when they were available."

Mrs A stated that at about 12.30am she spoke to a nurse and she told her where to bring the car. When she picked up her husband at the door, he had a prescription and Discharge

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Summary form in his hand. The form contained no blood test results, follow-up instructions or discharge advice. The form was signed by Dr C.

In response to Dr C's comment that her husband wanted to leave, Mrs A said: "He [her husband] had been ordered to leave 'when he was ready' [pain free]. The doctor had disappeared, and as far as we knew, was not coming back, so there seemed to be nothing else to do."

At the Coroner's inquest, Mrs A also stated:

> "… if there had been any suggestion at all that we should wait for the doctor's return or wait for the blood test results, any slightest hint that we should wait, we should never have gone home that night."

In a statement for the Coroner's inquest, Dr C stated:

> "I was very busy for the rest of the night. We had an exceptionally heavy patient load that night, 54 patients having come in during the day with further 17 coming in during the night. I believe that it was [as] a consequence of this that I overlooked following up the blood test results before I went off duty the next morning, and also was unable to make more comprehensive notes of my examination of [Mr A] and clinical impressions."

The emergency specialist giving evidence for Dr C, noted that Dr C intended to check blood test results but did not do so because of work pressure. The emergency specialist stated:

> "In a busy emergency department, it is inevitable that on occasions doctors will fail to follow up on blood test results. Hospitals should have a system in place to pick up such oversights. It appears that the safety net (if the treating doctor misses the results, a doctor on the following shifts should see them) did not work as it should."

The emergency specialist also stated:

> "After an initial assessment and starting pain relief, it is ideal to review the patient. However, if a doctor has formed an impression that the initial diagnosis is probably established and he has other cases that are considered to be more urgent to assess, he may prioritise his time to what he considers are more pressing issues and have insufficient time for review of cases. This issue of time management is a difficult balancing act for doctors starting in their first year in ED."

The following day, Mr A's condition did not improve. Mrs A said that when they arrived home at about 1.30am, her husband was falling over. She attributed that to the medications he had taken. Mr A slept for the rest of the night and most of the next day. That night he got up frequently, indicating that he needed to go to the toilet, but collapsing on the floor before he got there. By morning he felt "dreadful".

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Readmission to hospital
At 7.30am, Mrs A telephoned the medical centre in a nearby town for advice. She was told to immediately call for an ambulance. The ambulance was called at 8am and arrived at 8.02am. The ambulance report states:

> "O/A [on arrival] Pt [patient] lying on bed, alert & responsive. Hx [history] has been getting back pain / abdo pain all night, hasn't been eating & drinking… Hasn't been able to stand & walk. O/E [on examination] Pain extreme on palpation to LLQ [lower left quadrant], abdo rigid, stabbing pain… Temp 35.2°C @ 0824 [hrs]."

Mr A's blood pressure at 8.10am was 100/60 and pulse rate 88. Oxygen saturation was 85%.

The ambulance arrived at the public hospital Emergency Department at 8.50am. On triage Mr A's blood pressure was 122/38, heart rate 58 and temperature 37.5ºC. Standing blood pressure could not be obtained at 9.40am as Mr A felt very dizzy and passed out. "Likely bowel pathology, ??? AAA [abdominal aortic aneurysm[1]]" was suspected. An urgent ultrasound was performed at 10.30 and a leaking abdominal aortic aneurysm diagnosed. Mr A was immediately taken to the operating theatre for a repair of the ruptured aneurysm. The surgery was performed by a vascular surgeon. The operative finding was a "large left-sided retroperitoneal haematoma with a 6cm abdominal aortic aneurysm in the infararenal position."

Following surgery, which was completed at 1.40pm, Mr A was transferred to the Intensive Care Unit for management on a life support system. Mr A developed postoperative complications, including ongoing bleeding, coagulopathy (blood clotting disorder) and hypothermia (abnormally low body temperature). His condition continued to deteriorate and at 10.30pm he died.

An autopsy was performed at the request of the Coroner. The autopsy report stated the cause of death as "ruptured atheromatous aneurysm of the abdominal aorta". The "comment" section stated:

> "Histology has revealed severe renal disease in addition to the features noted macroscopically. This would have increased his likelihood to develop renal failure following a drop in blood pressure from the ruptured aneurysm but in my opinion, this is not a significant factor leading to death and the cause of death should remain as given above."

Internal review
Dr C advised me that after learning of Mr A's death, he requested that the case be discussed at the hospital's Mortality and Morbidity Conference the following month. The purpose of the conference was to ensure that any issues raised about a particular patient's management

[1] An abnormal balloon-like swelling in the wall of the aorta in the abdominal segment of the vessel. The aorta is a major blood vessel that carries oxygenated blood from the heart to the rest of the body.

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in hospital were addressed, so that any learning or systems issues could be dealt with. Dr D stated that:

> "The result of this review was really re-emphasising to the doctors that acute results must be seen before the patient is discharged and as a secondary step that the review pile of reports should be reviewed regularly".

When asked whether any action had been taken as a result of the conference, Dr D stated:

> "… There was no new action taken because the system was there before. All that was required was to comply with the system so I had to remind the doctors to comply with the existing system."

In a letter to the Coroner dated 17 December 2003, Dr D described the public hospital Emergency Department Laboratory Result Review and Reporting System as follows:

> "ED requests blood tests. Blood samples are sent to the laboratory. The laboratory processes blood tests. The results are loaded onto the system electronically. When all the results have been loaded, the report is printed off automatically on a dedicated printer in ED. The report is final. The report is then picked up by the doctor, the nurse, or the clerk, and placed with the patient's notes. The doctor checks the results and signs them off immediately. The above is usually part of the decision making process during the patient's acute visit. The report is permanently filed.
>
> Examples of results printed off automatically on the ED printer are full blood counts (haemoglobin, white cell counts and differentials), urea, glucose, electrolytes, certain drug levels and cardiac enzymes. For various reasons a proportion of acute results are not signed. One of the reasons for this is that the doctor sometimes copies the results off the computer and hand-writes them into the patient's chart. All results that are not signed off on discharged patients will be placed in the review basket. Their charts are not retained and only recalled if required.
>
> Results that are not immediately printed off are usually results that take a few days to process, such as blood and urine cultures. They are posted to ED as hard copies and are placed in the review basket.
>
> A registrar or a senior medical officer (SMO) goes through the results in the review basket. This is usually done on a daily basis by the registrar or SMO on the 2.00pm duty shift. He or she then signs off all the normal results and they get sent to records for filing. When the results are abnormal the registrar or SMO will usually request the patient's charts by writing "Chart please" on the result sheet. This so the results can be reviewed in context. The clerk requests the charts from the medical records department. When these arrive they are placed with the report. The doctor then reviews the chart and takes action as necessary. Usually the doctor initials these reports once she or he has read the results and actioned them.

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The whole system works well when there are enough doctors on and the workload is not too busy. However, there are days particularly on the weekend, when ED is understaffed relative to a big patient workload. ED does not have control over numbers of patient attendances and as a result, at times, workload can become unexpectedly excessive. Results in the review basket are not reviewed during these busy times. However, every effort is made to review all acutely ordered results prior to the patient's discharge."

Dr D stated:

"I cannot say what happened in [Mr A's] case. There is no rule that says the morning staff are the sole designated reviewers of the night investigations. However, any registrar that is free is expected to review the results in the review basket as part of their normal duties. This could be the night staff or the day staff, but is more likely to be the afternoon staff. Flexibility is necessary because of the unpredictability on workloads."

When asked to explain the absence of a hard copy of Mr A's blood test results (of the evening he presented) in his records, and whether he had managed to locate them, Dr D stated:

"No, I haven't and I can't explain what could have happened that night. It is possible that the result was still in the review file and when [Mr A] turned up a couple of days later the result had not been reviewed and, in the setting of a new set of results, when you print off the computer you get the last several days' tests, the original one may have been discarded because it was redundant then."

Mr A's blood tests results (obtained from the computer record) showed haemoglobin of 88g/L (normal range 130-180g/L), haematocrit 2.28 (normal range 0.40-0.54), total white cell count 15.7 (normal range 4.0-11.0), neutrophils 13.36 (normal range 2.0-7.5), creatinine 0.17mmol/L (normal range 0.05-0.12), and glucose 12.1 mmol/L (normal range 3.5-7.7), all of which were significantly abnormal.

When asked whether any action had been taken in respect of Dr C, Dr D stated:

"[Dr C] and I had a discussion, as I would, with doctors who have been involved in similar instances, similar events. And we discussed what could have been done differently."

When asked what he thought could have been done differently, Dr D stated:

"In my opinion, the differential diagnosis of abdominal aortic aneurysm should occur in any elderly person presenting with back pain. And a doctor has to … satisfy … themselves that this is not an aneurysm. This can be done clinically, as obviously [Dr C] did, or by further investigations."

At the Coroner's inquest, Dr D stated that as a result of Mr A's case, the public hospital was looking at appointing a consultant to its Emergency Department to check blood results

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that had not been reviewed by the clinician who saw the patient, "to stop things from happening again".

Dr C stated that at the time of his examination of Mr A he considered but ruled out the likelihood of an abdominal aortic aneurysm as the cause of Mr A's symptoms. He stated:

> "Although I did initially consider abdominal aortic aneurysm, I discounted this as I regarded the clinical findings as consistent with musculo-skeletal pain. Mr A was clinically stable (and by that time he had been in A&E for about an hour and a half) and his pain was pinpoint and reproducible."

Although Dr C said that he initially considered and ruled out an abdominal aortic aneurysm, he did not record the differential diagnosis in Mr A's notes.

When asked what specific tests and examinations he performed to rule out an abdominal aortic aneurysm, Dr C said that "the only definitive test usually done to rule in or rule out AAA is a CT scan. I felt that I did not have enough evidence to order that at the time of my examination." When asked whether there was anything else he could have done that may have assisted his diagnosis, Dr C stated:

> "At that point of time … I could have insisted on him lying down or made him lie down but the pain was pretty localised and when a certain point it was really sort of one finger breadth where there was any pain so it was very localised and I mean I could have looked at the blood pressure a bit more cautiously but … I would not have given him the option of going home without the blood results, I would have insisted that they stay for the blood results, but in terms of clinical findings … particularly in light of what happened during the second visit I am not sure whether I would have had any more clues."

Dr C did not think that a more thorough examination would have led him to a different conclusion.
Regarding his follow-up of the blood test results and the documentation of his examination of Mr A, Dr C stated:

> "I was in error in failing to follow up the blood tests for [Mr A], and in failing to keep fuller notes of my examination and diagnosis of [Mr A]. This does not reflect my usual practice and certainly did not reflect indifference by me to providing appropriate care for [Mr A]. The night that I saw [Mr A] was unusually busy, and I was under intense work pressure. However I also understand that this does not excuse my error."

Dr C also stated:

> "I very much regret both failings on my part and the upset they have caused the family of [Mr A]."

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Independent advice to Commissioner

The following expert advice was obtained from Dr Scott Pearson, specialist emergency physician:

> "My name is Scott Pearson and I have been asked to provide an opinion to the Commissioner on case number 03/10460/WS. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I am a full time Emergency Physician at Christchurch Hospital. My qualifications are MB.ChB (1988) and FACEM (1996). I worked in a variety of hospital posts from 1990-1996 including Emergency Medicine whilst undertaking specialist training. I have worked in my current position since March 1999.
>
> **Background**
>
> … At about 10pm, [Mr A] was taken by ambulance to [the public hospital] Emergency Department with a complaint of back pain. He was assessed by [Dr C], a registrar, who made a diagnosis of musculoskeletal pain. Panadol, Codeine, Voltaren and Diazepam were prescribed by [Dr C]. [Mr A] was discharged at about 1am … before the results of his blood test (urea and electrolytes and complete blood count) were obtained. He was discharged on Panadol and codeine.
>
> The following day, … at about 9am, [Mr A] was readmitted to the hospital's Emergency Department. He was assessed by another doctor and, after further investigation, was diagnosed with abdominal aortic aneurysm. [Mr A] underwent emergency surgery but died of complications at 10.30pm that evening.
>
> The matter was referred to the Coroner. An inquest hearing was duly held on 29 March 2004. The Coroner has reserved his decision.
>
> **Supporting Information**
>
> - Letter of complaint and supporting documentation from [a Health and Disability Advocate] of Advocacy Services on behalf of [Mrs A] (pages 1-29) marked 'A'.
> - Record of telephone conversation with [Mrs A] (pages 30-31) marked 'B'.
> - Response from [the public hospital] to the Commissioner … including summary of services provided to [Mr A], statement from [Dr C], statement from [Ms E], and a copy of the hospital's triage process (pages 32-54) marked 'C'.
> - Letter of response from [Dr C] to the Commissioner … and a copy of his statement to the Coroner (pages 55-58) marked 'D'.
> - Letter of response from [Dr C] to follow-up questions from the Commissioner's office … (pages 59-61) marked 'E'.
> - Letter from [the barrister] acting for [Dr C] dated 22 April 2004 including a copy of the Coroner's report, report from […] to the Coroner, evidence provided at the Coroner's Court by […], transcript of evidence from the Coronial inquest and the submission filed on behalf of [Dr C] (paged 62-129) marked 'F'.

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- Letter from [Mrs A] to the Commissioner's office dated 3 April 2004 (page 130) marked 'G'.
- [Mr A's] records from [the public hospital] (pages 131-212) marked 'H'.

What specific professional and other relevant standards apply in this case and did [Dr C] follow them?

There are no specific standards that apply to this situation. The closest description in terms of a standard are the accounts given by locally (Australasian) produced textbooks in terms of assessment of individuals attending an Emergency Department (ED) with back pain and also individuals attending with symptoms where the possibility of an acute abdominal aortic aneurysm is raised (see enclosures). To this end I have referred to one text previously described in the Coroner's hearing and one further.

To my knowledge, there is no locally produced guideline at [the public hospital] ED for assessment of individuals attending with back pain. In the absence of a specific standard 'the standard' is really defined by those individuals who practise in Emergency Medicine i.e. did the individual health professional [Dr C] observe a standard of care and skill reasonably to be expected in the circumstances?

[Dr C] states the possibility of abdominal aortic aneurysm was considered as a possible diagnosis [when Mr presented]. I therefore believe he erred from a reasonable standard due to the nature of his assessment (see below).

Was [Dr C's] examination of [Mr A] appropriate and adequate?

There is some disparity between the examination conducted by [Dr C] and that witnessed by [Mrs A] who was present throughout the examination. [Dr C] documented that [Mr A] was comfortable with pulse 97/min. Some notes are difficult to read but suggest normal heart sounds with no murmurs, normal breath sounds and normal abdominal examination. Regarding the back 'localised tenderness area in the lumbar region, pinpoint and reproducible, no spinal tenderness'. The above details were reinforced by [Dr C] in his letter to Clinical Director [Dr D] on 20 May, 2003. In this letter, [Dr C] also makes note of the blood pressure (recorded as 92/52 mm Hg on the right arm and 105/55 on the left arm). Noted also was the fact that [Mr A] was examined in the sitting position 'as the nurses had already told me that [Mr A] was unable to get into bed.' They had stated to me that this was aggravating the pain and that he was most comfortable sitting in a chair. In a further 3 page statement by [Dr C] (unsigned and undated) he states 'my thinking at that stage was then to wait for the painkillers to work, at which time I would come back and do a more thorough physical examination' (point no. 7). Further 'no jaundice; was not, on clinical examination, anaemic; no clubbing; no cyanosis; no feet oedema and no lymphadenopathy' (point no.9). None of these negatives were documented in his original clinical notes. Detecting lymphadenopathy would require examination of both axillae, both groins and also the neck region. One might expect that such an examination of the groins may be difficult in the seated position. An observer might be expected to recall an examination.

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[Dr C] further comments that he considered the blood pressure to be low, however dismissed this as an isolated finding.

In my opinion, the above examination was inadequate for the following reasons:

- [Mr A] was examined in a seated position initially. [Dr C's] intention was to return and conduct a more thorough examination. This did not happen. This is despite [Dr C] considering the possibility that [Mr A's] pain may be due to an abdominal aortic aneurysm (AAA). I would expect [Dr C] to examine the abdomen in a supine position.
- [Mr A's] blood pressure was considered low. I concur that this is a low blood pressure for a 75yr old man (on no blood pressure altering medication) who was also in pain. This was dismissed as an isolated finding in a stable and otherwise normal clinical examination (point no. 10). However the blood pressure was not repeated.
- In the context of an elderly man attending the ED with severe lower back pain, if the doctor believes the pain to be of musculoskeletal origin, I would consider it reasonable to expect an assessment of the lower limbs. This, in my opinion, means an assessment of lower limb power and sensation, signs of nerve or spinal cord compression, and ultimately ability to walk. This may have occurred but there is no evidence of this in the reports from Dr C that I have viewed.

[Mrs A] outlines in her letter … her recall of the interaction between [Mr A] and [Dr C]. She describes [Dr C] pushing on the lower back where [Mr A] was describing the pain. No other examination was performed. At the meeting at [the public hospital] on 17/4/04, [Mrs A] refuted the examination of the cardiorespiratory system and abdomen described by [Dr C]. In her letter … [Mrs A] again clearly states, 'the doctor did not touch the abdomen'.

Did [Dr C] conduct appropriate and necessary tests?

Considering the diagnosis of musculoskeletal pain, there would be no specific requirement for any tests. The fact that [Mr A] was 75 years old and being treated with steroids are considered red flags in assessing individuals with back pain i.e. one should consider more serious causes of the back pain (see enclosed ACC Treatment Guidelines). However, given that the back pain had only been present for 5 hours, it would be reasonable not to perform specific tests at the time of the [initial] attendance. [Dr C] also considered the possibility of AAA. A doctor may exclude potential diagnoses based on historical information (obtained from the patient) or examination findings. If a potentially serious condition cannot be excluded by the above, then additional tests will be required. The appropriate tests to detect AAA are ultra sound or CT imaging. This was not done because [Dr C] had excluded this possibility based on his clinical findings. I consider this to be acceptable practice.

Was [Dr C's] diagnosis of musculoskeletal pain reasonable in the circumstances and were there any indicators that [Mr A's] pain was other than musculoskeletal in origin?

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In the information available to me, it is not clear how [Mr A's] pain started. [Dr C] describes it as sudden in onset but does not describe the activity (if any) [Mr A] was undertaking. It is possible that [Mr A] was at rest when the pain began which would tend to favour an alternative aetiology other than musculoskeletal pain. I concur that pain in the lumbar region with associated tenderness may lead a clinician to the diagnosis of muscular pain. However, other factors would concern me in making this diagnosis:

- [Mr A's] age
- There being no past history of back pain
- The onset of the pain – sudden
- The severity of the pain (10/10 in ambulance record though improving spontaneously)
- The requirement of [Mr A] to attend hospital late in the evening due to his pain may be considered a further indicator of its severity
- The low blood pressure
- His inability to 'get comfortable' and reluctance to lie down.

None of these factors in isolation are necessarily alarming but considered altogether, represent significant suspicion, in my view, of an alternative aetiology.

I also note the enclosed extracts from texts that reinforce the differential diagnosis of an elderly man attending ED with back pain.

Did [Dr C] give adequate consideration to the possibility that [Mr A's] pain may be due to an aortic aneurysm and was an aortic aneurysm ruled out on reasonable grounds?

As already stated, potential diagnoses can be ruled out on clinical grounds alone or may require the use of additional tests. Depending on experience and seniority, different clinicians will vary on their confidence on clinical assessment and their need to use diagnosis adjuncts. One must also consider the evidence available in terms of sensitivity of the clinical examination or test for detecting certain pathology.

[Dr C] considered the possibility of AAA but then did not perform an abdominal examination of [Mr A] in a supine position. [Mr A's] weight at the time of Post Mortem was 60 kg, height 161cm (not obese) and the estimated size of the AAA on ultrasound on [the day he died] was 6 cm. This would increase the likelihood of detecting the AAA by clinical examination. However, failure to examine the abdomen in a supine position would decrease the likelihood of detecting an AAA, in my opinion. If [Dr C] had been aware that palpation of a pulsatile abdominal mass was possible in <50% of AAA, he may not have relied on clinical examination alone to exclude this possibility. However, this is speculative on my part.

A more senior clinician may have recognised the difficulty of clinical examination alone to detect an AAA. It is a matter of clinical judgement as to whether diagnostic adjuncts are required to 'rule out' a particular diagnosis. However, in my opinion, if a clinician

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considers this as a diagnostic possibility then examination of the abdomen in the supine position is mandatory.

Was it appropriate for [Mr A] to be discharged before the results of these blood tests were known?

As stated by witnesses in the enclosed documents, many hospital EDs now have a process whereby nursing staff perform blood tests on patients prior to formal assessment by the doctor. There may be internal guidelines to provide direction in terms of what blood tests (if any) are required. Such processes have been developed in order to reduce waiting times for individuals attending Emergency Departments. This process is invariably with the support of the Emergency Department Clinical Director. Responsibility for checking such blood test results, in my opinion, rests with the doctor who then assesses the patient. There may be differing views on this issue. However, my view is that, although medical staff may have delegated test-ordering authority to nursing staff in certain circumstances, medical staff are still responsible for the follow up of such tests. It has been clearly stated on the emergency record that blood tests were taken at 2315 hours on [the evening Mr A presented]. It would have been preferable that these blood test results were checked prior to discharging [Mr A]. However, [Dr C] was of the opinion that [Mr A's] pain was benign (muscular) and was not concerned about other causes. [Dr C] has stated that he wished to see the results prior to discharging Mr A but was then informed that [Mr A] was pain free and wished to go home. I note these details are inconsistent with [Mrs A's] recall of events. [Dr C] then became busy with other patients and overlooked checking the blood test results.

Was it appropriate to discharge [Mr A] [on the night he presented]?

[Dr C] made a diagnosis of muscular pain and therefore it was very reasonable to discharge [Mr A]. However, we now understand this diagnosis was incorrect. I do not find this alarming in itself. We know that the diagnosis of AAA can be difficult and initially incorrect in up to 30% of patients. It is concerning that the above decision was made after an examination which, in my opinion, was inadequate.

Given the blood test results [on the evening he presented] and haematology in particular, should [Mr A] have been recalled to hospital? If so, and in the circumstances, whose responsibility was it to recall [Mr A]?

Every ED has a process for dealing with blood test results. Each hospital may have particular variations but essentially most EDs rely, initially, on individual doctors checking the results for the patients they assess. This is usually done electronically by accessing a computer terminal although some EDs may use fax or telephone facilities. A 'paper copy' of the results is then generated by the laboratory and forwarded to the ED. This usually occurs within 24 hours (in larger EDs). Each ED will then have a process whereby these paper results are checked by a doctor. Any results that are of concern are matched with the clinical notes and a decision made as to whether the patient should be contacted or recalled to hospital. This represents a 'second check.'

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This process is reliant on the existing medical staff checking the paper results and then asking reception staff to match the clinical notes if abnormal results are found. This is a time consuming process. Medical staff add this task to the constant demand to assess new patients attending the ED. In times of high patient numbers, the demands on doctors increase. It is likely that the 'second check' process may be delayed or fail due to existing patient workload. Paper copies may be misplaced or even 'lost'. Consequently there is a risk that the above mechanism may fail. This has obviously happened at [the public hospital] regarding [Mr A].

Such a system can be 100% effective (or very near). This would require allocation of sufficient time every day for one doctor to carefully review all test results and contact patients as required. This task would be independent of patient demands.

[The public hospital] ED had a system in place for checking blood test results. The first system ([Dr C]) failed because he was busy and overlooked this task. This is a moderate deviation from acceptable practice but one that is understandable given the other demands on him at that time. The 'second check' also failed. Had the blood test results been known to medical staff, I would have expected contact by telephone with the patient or GP and probably recall to hospital for review. However, in my opinion, it is difficult to apportion responsibility for this failed process. If the expectation exists that this process is 100% effective, EDs will require extra resources to implement this.

Are there any other issues that arise from [Dr C's] responses and other information provided?

- I have observed the comments regarding legibility of [Dr C's] clinical notes. There seems to be a number of readers who have had difficulty reading these clinical notes (including myself). I accept that quality of clinical notes does not correlate to quality of care. However, should a patient subsequently return to ED for further care, other health professionals will need to read those clinical notes, and this may be important. Whilst not a direct criticism of [Dr C], legibility of clinical notes is important for this reason.
- Ingestion of Voltaren. Counsel for [Dr C] has suggested that the Voltaren was not taken on [the evening he presented] because it was not signed for in the medical record. [Mrs A] notes in her letter to HDC (3/04/04) that [Mr A] initially refused the Voltaren but it was left in the room. He subsequently decided to take the Voltaren (unwitnessed by any health professional and therefore not signed off on the medical record).

I enclose photocopies of chapters from two relevant textbooks in the field of Emergency Medicine produced in Australasia. Relevant sections are highlighted and underlined. I also enclose ACC Treatment Guidelines for Low Back Pain.[2]

[2] Not attached to Commissioner's report.

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References

1. Cameron P, Jelinek G, Kelly AM et al. Textbook of Adult Emergency Medicine. Churchill Livingston, 1998. Chapters on Aneurysms and Rheumatology (Back Pain).
2. Fulde GWO. Emergency Medicine – The Principles and Practice. 3rd Edition, 1998. Chapter on Ruptured Aortic Aneurysm.
3. ACC Treatment Profiles 2001 – Low Back Pain."

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

Opinion: Breach – Dr C

Dr C's assessment of Mr A
Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) Mr A was entitled to have services provided with reasonable care and skill by Dr C.

Dr C saw Mr A at about 11.15pm, an hour and a half after he was brought to the Emergency Department by an ambulance and after the initial assessment by a triage nurse. Prior to seeing Mr A, Dr C was aware that Mr A presented with back pain, and noted his medical history and vital signs as recorded by the triage nurse. Dr C prescribed Panadol, Voltaren and diazepam, which were taken to Mr A an hour earlier. Dr C was also aware that Mr Awas uncomfortable, unsettled, and did not want to lie down because it made his pain worse.

There is some discrepancy between the accounts of the examination described by Dr C and Mrs A, who was with her husband throughout his stay in the Emergency Department. Whereas Dr C stated that he examined Mr A's cardiovascular and respiratory systems, his abdomen and back (having established pinpoint and reproducible tenderness over the left lumbar region), Mrs A had no recollection of Dr C touching her husband's abdomen or listening to his chest.

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Dr C acknowledged that he examined Mr A in a sitting-up position, contrary to his usual practice of examining patients in a lying down (supine) position. This was because Mr A's pain was aggravated when lying down. Dr C also acknowledged that this examination of Mr A was not a full assessment and that he was intending to return to perform a more thorough examination. Because of a heavy work load this did not happen.

My advisor, Dr Pearson, was of the opinion that Dr C's examination of Mr A on the night he presented was inadequate. The reasons given by my advisor are as follows:

> "Firstly, [Mr A] should have been examined in a supine position. This was particularly important given that [Dr C] considered that [Mr A's] pain could be due to an abdominal aortic aneurysm. The likelihood of detecting the aneurysm in a supine position is greater than if the patient is examined in a seated position."

My advisor was of the opinion that "if a clinician considers this [abdominal aortic aneurysm] as a diagnostic possibility then examination of the abdomen in the supine position is mandatory".

Although Dr C intended to return and perform a more thorough examination, presumably with Mr A in a supine position, that did not happen.

Secondly, Mr A presented with a low blood pressure (92/52 on his right arm and 105/55 on his left arm). Dr Pearson considered this to be a low blood pressure for a 75-year-old man who was in pain and on no blood pressure altering medication. Although the low blood pressure was dismissed by Dr C as "an isolated finding in a stable and otherwise normal clinical examination", Dr C did not take or request another blood pressure reading.

Thirdly, Dr C's conclusion that Mr A's back pain was musculoskeletal in origin seems to have been made without the assessment of Mr A's legs. My advisor stated:

> "In the context of an elderly man attending the ED with severe lower back pain, if the doctor believes the pain to be of musculoskeletal origin, I would consider it reasonable to expect an assessment of the lower limbs. This, in my opinion, means an assessment of lower limb power and sensation, signs of nerve or spinal cord compression, and ultimately ability to walk."

No evidence was presented that such an examination took place.

I acknowledge the discrepancy in the accounts of Mr A's clinical examination provided by Dr C and Mrs A. However, based on the documentation available to me and the advice from Dr Pearson, I consider that the clinical examination of Mr A was incomplete and inadequate.

Mrs A had no recollection of Dr C enquiring about her husband's past medical history other than ulcerative colitis, the medications he was on, and when the pain started. She recalled nurses, not Dr C, asking these questions.

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Although it is not clear what past medical history was obtained by Dr C and what was obtained by nursing staff, my advisor noted that it was not clear how Mr A's pain started. Dr Pearson commented:

> "[Dr C] describes it [the pain] as sudden in onset but does not describe the activity (if any) [Mr A] was undertaking. It is possible that [Mr A] was at rest when the pain began which would tend to favour an alternative aetiology other than musculoskeletal pain. I concur that pain in the lumbar region with associated tenderness may lead a clinician to the diagnosis of muscular pain. However, other factors would concern me in making this diagnosis."

The "other factors" identified by my advisor included Mr A's age, there being no past history of back pain, sudden onset of pain, the severity of pain, Mr A's decision to seek medical attention late at night, low blood pressure, Mr A's inability to "get comfortable" and his reluctance to lie down. The advisor stated:

> "None of these factors in isolation are necessarily alarming but considered altogether, represented significant suspicion, in my view, of an alternative aetiology."

Dr Pearson commented that given the fact that Mr A was 75 years old and was treated with steroids, consideration of a more serious cause for his pain was indicated. Dr C said that he considered the possibility of an abdominal aortic aneurysm (but did not record it in the notes) but ruled it out on clinical examination. Given that Mr A's back pain had been present for only about five hours and Dr C excluded the possibility of abdominal aortic aneurysm based on his clinical findings, my advisor considered Dr C's decision not to request an ultrasound or CT imaging as reasonable. My advisor recognised that a diagnosis of an abdominal aortic aneurysm can be difficult and was not critical of the fact that a wrong diagnosis was made. He stated:

> "I do not find this [incorrect diagnosis] alarming in itself. We know that the diagnosis of AAA can be difficult and initially incorrect in up to 30% of patients. It is concerning that the above decision was made after an examination which, in my opinion, was inadequate."

In summary, based on the documentation available to me and the advice I have received, Dr C's clinical examination of Mr A was inadequate and he failed to give significant weight to the factors that collectively suggested a more serious alternative cause for Mr A's presenting symptoms. In my view, Dr C did not exercise reasonable care and skill when he assessed Mr A and, therefore, breached Right 4(1) of the Code.

Follow-up of blood test results and review prior to discharge

Dr C said that after the initial examination of Mr A, he was intending to return and perform a more thorough examination when Mr A was pain free and when the blood test results were known. Dr C acknowledged that the second examination did not take place and that the blood tests results were not available at the time Mr A left the hospital. Nevertheless,

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Mr A was formally discharged. The Discharge Summary was completed and signed by Dr C.

Dr C's explanation surrounding Mr A's discharge was that he was told by a nurse that Mr A was pain free and that he wanted to go home. He communicated to the nurse that he "would prefer him to wait until the blood test results were available but if Mr and Mrs insisted on going they could". This appears incongruent with another statement made by Dr C that he could not recall whether he asked Mr and Mrs A to wait for the blood test results. Although it is not clear how he came to complete the Discharge Summary, Dr C indicated that as Mr A's presentation was consistent with musculoskeletal pain, he had no concern about him going home. Because he became busy with other patients, he did not go to see Mr A.

Dr C's account surrounding Mr A's discharge is inconsistent with that provided by Mrs A. She said that after Dr C left, she and her husband were left with an impression that he was not coming back. After about 20 minutes they decided to leave, assuming that they would have been told by the doctor if they needed to wait for the blood test results or if the results were abnormal. Mrs A did say that had there been any suggestion that they should wait for the doctor to return or wait for the blood test results, they would not have gone home that night. They left the hospital with the knowledge and assistance of a nurse from the Emergency Department, who gave them a prescription and the Discharge Summary completed by Dr C.

On balance I am inclined to accept Mrs A's version of events, which cast some doubt on Dr C's claim that he intended to return, conduct a more thorough examination, and review Mr A in light of the blood test results (and discharge when the blood tests were known to be satisfactory). If that was Dr C's intention, he did not record it in his clinical notes or apparently communicate it to Mr and Mrs A or other staff. His notes merely record a diagnosis of "musculoskeletal pain" and the plan "(1) Panadol/ Voltaren, diazepam, codeine (2) Discharge when pain free." This is consistent with Mrs A's recollection of being told that they could go home when the "pills have worked" and Mr A "felt better".

My advisor stated:

> "Responsibility for checking such [acute] blood results, in my opinion, rests with the doctor who then assesses the patient. … It would have been preferable that these blood test results were checked by [Dr C] prior to discharging [Mr A]."

In summary, based on information available to me and the advice I received, Dr C, in my opinion, failed to check the results of Mr A's blood tests and to review him in light of the results before discharging him. He also failed to communicate to Mr and Mrs A any intention to review Mr A, his management plan or any follow-up advice. In my opinion, Dr C did not provide services with reasonable care and skill and did not provide Mr and Mrs A with appropriate information. Accordingly, in my opinion, Dr C breached Right 4(1) of the Code.

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Other comment
My advisor commented on the legibility of Dr C's clinical notes, and the fact that he had difficulty reading them. Dr Pearson observed that other readers had the same problem. While he accepted that the quality of clinical notes does not necessarily correlate with the quality of care, he made the following comment:

> "… should a patient subsequently return to ED for further care, other health professionals will need to read those clinical notes, and this may be important. Whilst not a direct criticism of [Dr C], legibility of clinical notes is important for this reason."

The Medical Council of New Zealand "Guidelines for the Maintenance and Retention of Patient Records" (October 2001) state:

> "1. Maintaining patients records
>
> a) Records must be legible and should contain all information that is relevant to the patient's care.
>
> b) Information should be accurate and updated at each consultation. Patient records are essential to guide future management, and invaluable in the uncommon occasions when the outcome is unsatisfactory."

I draw this matter to Dr C's attention and recommend that he review his record-keeping accordingly.

Opinion: Breach – Public hospital

Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code. 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 employees doing or omitting the thing that breached the Code.

Dr C was an employee of the public hospital. It was in his capacity as an employee of the hospital that he assessed and treated Mr A.

Although Dr C breached Right 4(1) of the Code by failing to perform an adequate clinical examination, give due weight to factors that pointed to a more serious aetiology, and to consider the blood test results before discharging Mr A, these matters involved clinical decisions and communication skills of an individual practitioner, and were not reasonably foreseeable or preventable by the hospital. The Board is therefore not vicariously liable for Dr C's breach of Right 4(1) of the Code.

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However, my investigation and the evidence produced at the Coroner's inquest indicate that while Dr C failed to check Mr A's blood test results, this omission was not picked up by the Emergency Department's checking system.

My advisor noted that most Emergency Departments initially rely on individual doctors to check the blood test results of the patients they assess. This "first check" is usually done electronically by accessing a computer terminal. A "paper copy" of the results is then generated by the laboratory and forwarded to the Emergency Department, usually within 24 hours. Each Emergency Department will then have a process whereby these paper results are checked by a doctor. Any results that are of concern are matched with the clinical notes and a decision made as to whether the patient should be contacted or recalled to hospital. This constitutes a "second check". Dr Pearson stated:

> "In times of high patient numbers, the demands on doctors increase. It is likely that the 'second check' process may be delayed or fail due to existing patient workload. Paper copies may be misplaced or even 'lost'. Consequently there is a risk that the above mechanism may fail. This has obviously happened at [the public hospital] regarding [Mr A]."

In this case, the "first check" (Dr C) and the "second check" (the Emergency Department system) both failed. My advisor stated:

> "Had the blood test result been known to the medical staff, I would have expected contact by telephone with the patient or GP and probably recall to hospital for review."

That did not happen and, for inexplicable reasons, the "paper copy" of Mr A's blood test results was never located.

Whereas I accept that a recall of Mr A to hospital for review and earlier surgery may not have altered the outcome, the hospital's failure to identify and act on abnormal blood test results raises serious concerns. It seems that in this case the Emergency Department at the public hospital did not have a sufficiently robust system in place to identify and follow through an abnormal blood result. Accordingly, in my opinion, the public hospital failed to provide systems with reasonable care and skill and is directly liable for this breach of Right 4(1) of the Code.

Actions taken

- After learning of Mr A's death, Dr C requested that his case be discussed at the public hospital's Mortality and Morbidity Conference, so that any management issues raised could be addressed and learned from, and any systems issues dealt with.

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- In response to my provisional opinion, Dr C stated through his lawyer:

  "[Dr C] reflected carefully on the circumstances of this case. He has demonstrated the insight to appropriately acknowledge failures in the care which he provided Mr A, and to learn from the experience. He has already made adjustments to his practice in respect of presentations such as that of [Mr A]. He has also confirmed that he is taking greater care in complying with the Medical Council's Guidelines for the Maintenance and Retention of Patient Records.

  As the provisional report records, [Dr C] has already expressed regret for his failings, and for the distress suffered by [Mr A's] family. He has asked me to confirm his willingness to meet with the family in order to apologise personally, should that be their wish."

- Dr C expressed regret for his failings and the upset they have caused Mr A's family. He expressed willingness to meet with the family and personally express his apology for the omissions. This was expressed by him at the Coroner's inquest, when he stated: "I would like to express my condolences and regret any distress my actions overtly might have caused."

- Since 12 January 2005, a procedure has been in place for checking laboratory results for patients in the Emergency Department at the public hospital. This states: "All acutely ordered blood tests must be reviewed by a doctor prior to discharge of the patient."

- In response to my provisional opinion, the public hospital has made an apology to Mrs A for its breach of the Code.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand.

- A copy of this report, with details identifying the parties removed, will be sent to the Australasian College for Emergency Medicine and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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