

**Assessment of man presenting to
emergency department with back pain
(03HDC10460, 24 February 2005)**

Emergency medicine registrar ~ Public hospital ~ Emergency department ~ Back pain ~ Abdominal aortic aneurysm ~ Differential diagnosis ~ Examination ~ Investigation ~ Review of test results ~ Premature discharge ~ Communication ~ Follow-up ~ Record-keeping ~ Systems ~ Standard of care ~ Vicarious liability ~ Right 4(1)

A woman complained about the services provided by an emergency department registrar to her 75-year-old husband. The man was taken by ambulance to the emergency department, as he had sudden-onset back pain and had noticed blood in his faeces. He had a history of ulcerative colitis.

The registrar was unable to examine the man for about one-and-a-half hours. In the interim, he ordered blood tests and prescribed pain relief on the basis of the triage nurse's assessment.

The registrar's heavy workload meant that he was unable to conduct a full assessment but he concluded that the pain was of musculoskeletal origin. While he had considered an abdominal aortic aneurysm as a diagnostic possibility, he ruled it out upon clinical examination. The man and his wife did not know that the doctor intended to examine the man further and to look at his test results before discharge, and so asked to go home. The registrar signed out the discharge summary, assuming that their wanting to go home meant that the pain relief had worked. He did not follow up the test results, which were abnormal.

Over the next day-and-a-half, the man's condition deteriorated and he returned to the hospital. An abdominal aortic aneurysm was discovered and operated on, but complications developed and the man subsequently died.

It was held that the inadequate clinical examination and failure to give sufficient weight to factors that collectively suggested an alternative aetiology amounted to a breach of Right 4(1). The registrar also breached Right 4(1) by failing to check the test results and review the man before discharging him, and by failing to communicate the management plan and follow-up advice to the man and his wife.

The district health board was found vicariously liable for not providing a system that would pick up the registrar's failure to follow up on the test results.