

## **Misdiagnosis of patient suffering from abdominal aortic aneurysm (04HDC12081, 21 December 2005)**

*Registrar ~ Emergency department ~ Public hospital ~ District health board ~ Abdominal aortic aneurysm ~ Renal colic ~ Differential diagnoses ~ Vicarious liability ~ Right 4(1)*

The family of a 59-year-old man complained about the appropriateness of the care and treatment he received at the emergency department of a public hospital. He was taken to the emergency department by ambulance shortly after midnight with abdominal pain, vomiting and hypotension. The emergency department was informed of the man's impending arrival, in particular that he was a status 2 unstable patient. He was examined and assessed by an emergency department registrar, who provisionally diagnosed renal colic. The man underwent several investigations and received treatment. The registrar considered that the man's condition had stabilised and he was discharged home at approximately 5.30am. A few hours later the man collapsed at home and died. The cause of his death was a ruptured abdominal aortic aneurysm resulting in massive haemorrhage and shock.

It was held that the responsibility for the missed diagnosis should be shared between the registrar and the DHB. A busy and tired registrar cannot be excused from all responsibility because of systems failures. Registrars in charge of an emergency department overnight should pay particular attention to any relevant guidelines, should not hesitate to contact the on-call consultant, and should delay a patient's discharge until appropriate investigations have been undertaken. In these circumstances, the registrar breached Right 4(1).

Emergency departments in New Zealand rely on junior medical staff to call the on-call consultant or radiology services and to follow relevant guidelines. For such a system to be effective, it is essential that staff are properly trained and orientated in how to contact consultants and radiology services. Guidelines must be readily accessible at the point of care, used in practice, and regularly reviewed and updated. The registrar's evidence indicates that the renal colic guideline — that all patients with this diagnosis should be referred to a surgical or urology registrar for immediate management/follow-up — was commonly not followed in practice.

It was also held that the DHB was responsible for the system in which the registrar worked, and that the system was substandard. In these circumstances, the DHB was held vicariously liable for the registrar's breach of the Code.