# Bill of rights for Australia

**Peter Carter, Carter Capner, Brisbane**

APLA is supporting candidates for the 1998 Constitutional Convention running under the banner *Bill of Rights for Australia*.

The candidates are:-

Richard Carew (Qld); Cathy Henry (NSW); Jeff Coates (Vic); Jay Wetherill (SA); and David Clyne (WA)

In many ways the constitutional guarantee of individual rights, including a guarantee of the right of access to the common law, is more important to Australians than whether or not Australia becomes a republic.

The aim of the campaign is to hoist the Bill of Rights issue further up the agenda in the republic debate.

We need to get access to common law on the agenda of those already concerned about a Bill of Rights.

We also need to get the concept of rights firmly implanted in the consciousness of the public, so that they understand that they will be losing something of value every time a government seeks to curtail access to the courts in some way.

It is also an opportunity for APLA to build liaisons with other important community groups.

With a considerable degree of media exposure likely to be devoted to the republic issue over the coming months, this is an opportunity for our side of the rights debate to go on the offensive rather than act in a defensive situation which so often occurs.

We all wish the candidates the best for the campaign and election.

Members are urged to seek the support of their staff, colleagues and friends in building the vote for the Bill of Rights candidates, to help ensure that the rights Australians are entitled to take for granted are safeguarded and fundamental freedoms are preserved for future generations. ■

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# Failure to diagnose myocardic infarction

***Perth Hospital and Whitaker v Frost***

**Peter Carter, Carter Capner, Brisbane**

This is an unreported decision of the West Australian Full Court delivered on 26 February 1997.

On 6 April 1988 Mr Frost, aged 34, woke up with chest pain at 3.00am. At 4.00am he arrived at the Perth Hospital by ambulance with crushing chest pain.

A history was taken by the resident, Dr Whitaker. She ordered an ECG (done between 4.05am and 4.25am) and administered oxygen. A diagnosis was made "unlikely ischaemic chest pain - probably gastric".

He was later reviewed by the registrar ,who by then had the full history. The Registrar was aware from the history that Mr Frost had had a previous angiogram taken a year or so earlier which revealed no cardiac abnormality. At 7.00am he was allowed "to go home" and told to take analgesics for the gastric upset.

At 7.30am he went to bed at home after taking some disprin or aspirin. His wife made an appointment for him while he slept and took him to see Dr Esslemont at 10.15am.

Dr Esslemont, a GP, diagnosed that he had a myocardiac infarction. He sent the patient for a blood test which later in the day revealed elevated cardiac enzymes. At 8.00pm that evening Mr Frost returned on Dr Esslemont's advice to the Hospital and was admitted and appropriately treated.

The trial judge found the hospital and the resident both liable in negligence for failing to admit the patient for observation, further investigation including a second ECG, blood tests and more potent analgesics. The judgment was not for failing to diagnose the infarction per se.

This was a modest claim: damage to the left ventricle due to the delayed treatment. The plaintiff was awarded $10,000 for pain and suffering and loss of enjoyment of life and $2,000 for loss of life expectancy. The total damages were $12,500.00 which presumably included some expenses and interest.

The findings of fact of the trial judge were essentially as follows:-

- it was unlikely the infarction occurred before 4.00am given the normal ECG. [However there was some dispute of this and the judge assumed for his judgment it was around 3.00am]
- the infarction would have been detected had a second ECG been given at 6.00am or at any time before 9.00am

- blood tests for cardiac enzymes at any time prior to 9.00am would probably not have observed their presence

The cardiologists who were called to give evidence for the defence said that they would have admitted the patient and administered a second ECG by 6.00am or 7.00am but would not have expected an inexperienced resident to have necessarily done so. Neither the hospital or resident were held liable for failing to diagnose the infarction.

Rather they were liable for:-

- failure to put in place a proper system which ensured that persons presenting at the hospital with symptoms consistent with possible cardiac infarction were kept under observation for an appropriate period which in this case required a second ECG and the carrying out of cardiac enzymes blood tests.

### Standard of care

On appeal, a number of points were raised. It was argued by the defence that the standard of care commented on by the cardiologists was irrelevant and their views ought not to have been accepted. It was said that the only relevant standard expert view was that of a relatively junior resident.

The court however pointed to the evidence of Dr Esslemont (who had 36 years experience as a GP and previous emergency room experience in the UK) who was very firmly of the view in his evidence that the condition ought to have been diagnosed by the resident or alternatively at least suspected so that the patient was placed under further observation.

It was held by Malcolm CJ that the RPH emergency unit was expected to have at least the skill of an experienced general practitioner such as Dr Esslemont and accordingly his evidence was accepted as being evidence of the appropriate standard of care.

But what of the standard of care of a junior resident? Malcolm CJ applied the case *Wilsher v Essex Area Health Authority* [1987] 2 WLR 425. This was a case where there was negligence on the part of a junior doctor and junior nurses in a special care baby unit. The hospital sought to defend a substantial damages suit on the basis that the standard of care required of the doctor in the unit was only that reasonably required of doctors having the same level of qualifications and practical experience as the doctors in the unit i.e. a junior standard. That argument was dismissed.

It was held in *Wilsher* that:

- each member of the staff of the unit was required to observe the standard of the unit as a whole
- the standard to be observed was that of ordinarily skilled persons exercising or professing to have the special skill
- the standard was to be determined in the context of the particular posts in the unit rather than the person filling the post i.e. the task the doctor elected to undertake not the skill of the doctor himself

Exception - the above does not apply if the junior personnel referred his erroneous conduct to a superior for advice.

On such an analysis, the hospital would not be able to escape liability by providing unskilled personnel or appropriate means of diagnosis and treatment. In the *Frost* case the application of this principal meant that the inexperienced resident could not escape liability. She was negligent, the hospital was vicariously liable for her negligence and the hospital was also liable for the absence of a proper system to ensure the ongoing investigation and observation.

Ultimately however the resident was excused of liability because a further examination of the evidence by the Appeal Court revealed that it was not the resident's decision to send the patient home but rather that of the registrar.

Some further clinical defences were raised on the hospital's behalf. It was claimed that the patient was only 34 years old. The symptoms were not severe as normally expected from a person suffering cardio infarction. Only 15%-30% people who present with chest pain have it with a cardiac origin. None of these arguments impressed the Appeal Court or the trial judge.

### Causation

There was considerable discussion relating to the nature of the infarction. It was argued by the defence that the only thing that could have been done had the patient been correctly diagnosed other than on presentation or by 6.00am was the administration of thrombotic drugs to dissolve a clot. This however would only be the case if the infarction was thrombotic by nature. There was conflicting evidence as to whether or not the infarction was thrombotic or caused by muscle spasm, in which case such medication would have had no effect.

The court held that it could not conclude the nature of the infarction and it was merely speculation either way. The defence agreed that in such a case the plaintiff should fail altogether because he had not satisfied the onus of proof of causation. Because the case was pleaded as a claim for damages for loss of a chance that treatment would have been of some value, (not that the treatment would necessarily been effective) causation was made out.

It was held by Wallwork J:-

*In this case, in my view, the [patient] had to establish on the balance of probabilities that the contravening conduct caused the loss of an opportunity for treatment which had some value, that value being ascertained by reference to the degree of probabilities or possibilities. His Honour found that the [patient] lost the chance of having his heart muscle damage minimised or reduced by timely thrombolytic therapy. The [Patient] did not have to prove on the balance of probabilities that the treatment would have been effective, because in such a case as this that is too theoretical. Once it was established that the [patient] should have been given a second ECG, which was not given to him, he had established on the balance of probabilities that he had lost a valuable chance of getting some treatment which may have improved his position.*

Thus it appears that there is a difference and lower standard of proof in the causation issue if the case is pleaded as a "loss of chance" case and the plaintiff does not have to prove that the treatment would have provided a complete cure, simply that he had lost a chance of getting some treatment which might have provided some improvement. This distinction in that differing standard of care is an important one for lawyers to bear in mind in their pleadings.

Apart from this causation issue, the most relevant points to come out of this case are the comments on standard of care in respect of inexperienced staff, duty of hospitals and similar institutions to provide competent staff and a proper system and the provisional diagnosis issue. ■

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