of probabilities, there is a link between the needle-stick injury and the development of viral-like symptoms within 20 days of the incident. Both Professor Dwyer and Professor Wakefield believe that this would be sufficient to connect the applicant's development of CFS to the incident. Professor Gatenby also conceded that this history would provide a plausible link. Therefore while the Tribunal reiterates that it cannot be unequivocal about this, in view of the present limited state of relevant medical knowledge, it finds that a causal link between the applicant's apparent viral illness and his subsequent development of CFS is probable."

Concluding note

This case note is a very brief summary of a huge case involving 516 pages of "T" documents containing many medical reports and learned papers on CFS. This note does not purport to cover all issues but is submitted to assist other practitioners who may find themselves with clients with similar problems. ■

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Communicating with the disabled

***Thurgar v Singh & Ors*, NSW District Court, April 1997.**
Catherine Henry, Sydney

Catherine Henry

A medical negligence case run to trial but which settled on day 2 shows that there is still a significant way to go before medical practitioners understand the special needs of deaf clients. The case demonstrates the importance of medical practitioners (and lawyers) being aware of the communication resources available in the community and how to use them appropriately.

Allegations of negligent treatment.

The facts of the case were as follows. The plaintiff, a 59 year old profoundly deaf woman from Sydney sought advice in 1994 from her general practitioner, Dr Singh, in relation to vaginal bleeding. The communication between Ms Thurgar and Dr Singh was by handwritten notes. In late July 1994, Ms Thurgar was referred to a urogynaecological specialist, Dr Biswas, whom she had not consulted previously. Dr Biswas was the principal defendant.

A referral letter was written by Dr Singh, GP to Dr Biswas, but despite the client's deafness, no Australian Sign Language ("Auslan") interpreter was booked for the appointment and very little of her medical history or presenting symptoms were included in the referral letter. At the appointment with Dr Biswas, Ms Thurgar was forced to communicate through written notes as she did not use lip reading. Some of the notes which became available during the case revealed a very minimal level of communication and Dr Biswas, himself, indicated that he found it difficult to obtain a full medical history because of the absence of effective communication. Ms Thurgar was given written advice and a prescription.

A further consultation between Dr Biswas and Ms Thurgar was held at which no interpreter was present. Eventually, in September 1994, Ms Thurgar organised a hearing friend who could use Auslan to attend an appointment with her so that she could act as an interpreter. The friend who acted as an interpreter thought Dr Biswas was more interested in her ability to sign than Ms Thurgar's condition.

In September 1994, Ms Thurgar was referred to Blacktown Hospital for a curette and hysteroscopy. On admission a professional interpreter had been organised to gather information for admission. At the conclusion of the procedure Ms Thurgar was advised by a staff member that she should make an appointment with Dr Biswas six weeks after the surgery. She was not told that as a result of the hysteroscopy, a carcinoma on the lining of the uterus had been found.

About four weeks later Ms Thurgar still had vaginal bleeding. She again attended Dr Biswas' rooms for a consultation with a friend to interpret for her. That friend remembers remarks being made by the specialist's staff to the effect that Ms Thurgar could lip read but was pretending not to be able to. Again the specialist exhibited an unusual level of interest in the friend's ability to sign. Still, the plaintiff was not told she had cancer of the endometrium. Rather, when questioned by the plaintiff as to the cause of the continued bleeding, Dr Biswas replied that Ms Thurgar had a large bladder and should limit the amount of coffee she drank!

Towards the end of 1994 and as the symptoms continued, Ms Thurgar consulted other medical practitioners who were advised that uterine cancer had been detected as a result of the earlier procedure at Blacktown Hospital. As indicated, this had not been communicated to Ms Thurgar. As a result, Ms Thurgar was immediately scheduled for a radical hysterectomy. By the time this was to be performed the cancer had spread and she had to undergo radiotherapy which was not successful. Ms Thurgar died in June 1998.

Medical evidence presented at the hearing of the matter in the District Court was that had the cancer been treated

earlier it may have been more successfully treated and Ms Thurgar would have had a much longer life expectancy.

The basic principles

The lack of appropriate, or even adequate, communication formed the basis of Ms Thurgar's claim of negligence. The case was settled after two days of hearing and after the expert evidence as to the impact of the delay in treatment had been heard. The case demonstrates the importance of understanding by medical practitioners of the basic rules of interpreted communication to ensure that they meet their duty of care to their patients.

Despite being aware that Ms Thurgar was profoundly deaf, the practitioner did not arrange an interpreter for his own consultations with her nor indicate that this would be necessary when referring her for a specialist appointment. Neither did the specialist arrange for an interpreter even when he found communication difficult.

Ms Thurgar organised friends to interpret for her. The medical practitioners involved should have realised this was far from ideal. The use of medical terminology can sometimes be difficult for someone not trained as an interpreter to communicate to a friend or relative. Professional interpreters should always be used.

The specialist appeared to Ms Thurgar's friends to find interpreting a bit of a novelty. This could distract him from appropriate use of what interpreting was available. Effective use of an interpreter should not unnecessarily detract from effective communication with the person seeking medical treatment. Communication should always be directed to the patient or client and the interpreter used as a conduit for that communication. Likewise, remarks in relation to Ms Thurgar's ability to lip-read or otherwise indicated a lack of exposure to interpreting by the specialist's staff.

Access to Auslan interpreting services.

The principles governing the access to interpreters in Australia are most commonly associated with access for people of non-English speaking background. Access and equity principles appear in governmental policy and guidelines such as the NSW Government's *Ethnic Affairs Action Plan 2000* and the Commonwealth Government's draft *Charter of Principles for Public Service in a Culturally Diverse Society.* These principles recognise the importance of clear communication between people as the basis for the understanding and exercise of basic human rights and responsibilities. In very few cases is there a legal right to an interpreter and the *right* to an interpreter is reliant to a large extent on the policies of the organisation concerned.

Recently there has been a growing awareness that Auslan is a different language to English and these same principles are slowly beginning to be applied to access to Auslan interpreting services. For example, the NSW Ethnic Affairs Commission has recently included Auslan as a language group in which it is able to provide interpreting services.

What is so tragic in this case is that there was access to Auslan interpreting services at the relevant time in connection with health related needs in New South Wales. The Department of Health's Healthcare Interpreting Service provides free Auslan interpreting services in relation to public health services, including public hospitals, community health centres, early childhood centres and mental health centres. In Ms Thurgar's case, a professional interpreter was *only* used during the admission procedure at Blacktown Hospital.

In relation to private medical appointments, the Deaf Society is able to provide free Auslan interpreting services because they recognise the importance of clear communication between a medical adviser and a patient.

APLA lobbying for change

One of the difficulties in relation to Auslan interpreting services is that they are not *currently* included as a prescribed item on the Medicare Schedule of Benefits. This means that the ability to organise an interpreter is left to the knowledge of the client or practitioner of the available services. Some practitioners and clients may also be under the mistaken impression that there is a cost associated with Auslan interpreting services in medical matters. If a Medicare Schedule item to cover Auslan interpreting was introduced, this would raise the awareness of the medical profession of the availability of the service and ensure that interpreters were made available when required and as a routine part of practice. Likewise, this would also allow individuals to use fee for service interpreting such as that provided by the Ethnic Affairs Commission of NSW where free services were limited or not available.

APLA's medical negligence SIG is working with the NSW Deaf Society and the Disability Discrimination Legal Centre to raise awareness of the need for change in this area.

Ms Thurgar's experiences illustrate that despite education programs on effective communication aimed at the medical profession, there is still some way to go in practitioners recognising when communication difficulties can compromise their ability to provide appropriate medical treatment. ■

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