

Publication: Australian Health Law Bulletin
Date: February 2009
Page No: 5
Author(s): Guy Donovan (of Holding Redlich)
Publisher: LexisNexis

Case Note: Young v Central Australian Aboriginal Congress Inc [2008] NTSC 47

Justice Thomas of the Supreme Court of the Northern Territory has recently handed down a decision in which His Honour was critical of the systemic problems in the health care services provided by the Central Australian Aboriginal Congress Inc (**CAACI**). His Honour held that the CAACI had a responsibility to put administrative procedures in place to deal with patients who failed to attend appointments relating to potentially serious conditions. It was found that the system in place was “inherently unreliable” and CAACI breached its duty of care to its patient.

The Plaintiff’s claim

The Plaintiff, Rosario Young, claimed damages in negligence pursuant section 7 of the *Compensation (Fatal Injuries) Act* following the death of her husband, Clive Impu. The Plaintiff sued for her own benefit and the benefit of her 3 children.

Mr Impu died from a coronary thrombosis on 26 January 2001. The Plaintiff claimed that the First Defendant, CAACI, was negligent in that it failed to follow up testing of Mr Impu’s cholesterol levels and failed to follow up a referral to a specialist physician.

The Plaintiff also claimed that CAACI was vicariously liable for the negligence of the Second Defendant, Dr John Dominic Boffa. The Plaintiff claimed that Dr Boffa, was negligent in failing to properly diagnose and/or treat the deceased on 2 March 2000 and in failing to follow up on the deceased's diagnosis and treatment for suspected ischaemic heart disease.

The Defendants denied liability and in the alternative claimed contributory negligence on behalf of the Plaintiff.

Background and facts

On 2 March 2000, Mr Impu attended CAACI and consulted Dr Boffa, a specialist General Practitioner employed by CAACI. Dr Boffa obtained a history that Mr Impu was suffering from discomfort to the left side of his chest. Dr Boffa made an appointment for Mr Impu to attend a fasting cholesterol test on 6 March 2000 to investigate the possibility of ischaemic heart disease.

He also made an appointment for Mr Impu to attend the specialist physician clinic at CAACI on 21 March 2000.

Mr Impu failed to attend both appointments and this was not followed up by CAACI. On other occasions following 21 March 2000, Mr Impu returned to CAACI for consultations in relation to unrelated conditions. However, the practitioners he consulted did not review his failure to attend the arranged appointments.

On 26 January 2001 Mr Impu attended Dr Morrison at CAACI. Mr Impu complained of pain in his chest and was prescribed anti-inflammatory medication. Mr Impu collapsed on his way home from the appointment at CAACI and died shortly thereafter.

Duty of care of CAACI

CAACI operates as a publicly funded non-government organisation providing health care services. Justice Thomas held that it owed a duty of care to exercise reasonable care and skill in the treatment and care of Mr Impu as a patient of the general medical practice and clinic. His Honour held that it also owed a duty of care in the administration and management of the treatment and care of Mr Impu by its employed general medical practitioners, nursing and administrative support staff employed by it.¹

Ultimately, His Honour concluded that CAACI had breached its duty of care as set out in *Wyong Shire Council v Shirt*.² The court found that CAACI had a responsibility to put a reasonable administrative system in place to adequately address the situation where a patient fails to attend for a test, as is part of the treatment plan for serious conditions.³

Dr Tatjana Janusic, Medical Officer Co-ordinator, gave evidence that if a person failed to attend an appointment at the clinic and it was the first referral to the physician, a booking was made for a second appointment. If the patient failed to attend a second appointment then a third appointment would be arranged, and so on. However, if the patient was a regular attendee at the clinic and missed an appointment, there would be an entry in the patient's file to discuss making a new appointment at his or her next visit.

This system took away the responsibility of an individual doctor to follow up a patient. Accordingly, the court found that it was incumbent upon CAACI to devise a system that ensured patients were followed up when necessary.⁴

The evidence in this case was that following Mr Impu's failure to attend for his appointment on 21 March 2000, Dr Janusic was provided with a file to review because of the non-attendance. However, she was incorrectly given the file of another patient with the same name as Mr Impu and no follow up was made for the deceased. Regardless, the deceased did attend CAACI on a few occasions between 2 March 2000 and 26 January 2001 for various problems. However, he was not asked about the cholesterol test or his specialist appointment.

¹ *Young v Central Australian Aboriginal Congress Inc* [2008] NTSC 47 at 157 and 204.

² (1980) 146 CLR 40 at 47-48 Mason J.

³ [2008] NTSC 47 at 165

⁴ [2008] NTSC 47 at 211

In his judgment, Justice Thomas found that the system in place at CAACI had failed on a number of grounds, including:

- The receptionist retrieved the “incorrect” Mr Impu file.
- It was a requirement that referring practitioners put a pink slip referral form on file. There was no pink referral form in the “incorrect” Mr Impu file and its absence should have given rise to a query.
- The files were not marked to indicate there were 2 files in the name of Clive Impu.
- There was a note made by Dr Janusic on the “incorrect” Mr Impu file to sort out his referral at his next visit. This did not occur.
- The practitioners who saw Mr Impu when he attended CAACI following 21 March 2000 did not properly refer to the notes to alert them to the fact that the deceased had not attended important tests.
- When Mr Impu attended CAAC on 26 January 2001 Dr Morrison did not have his file.⁵

The court found that these errors amounted to a breach of CAACI’s duty of care. The follow up system in place at CAACI was inherently unreliable and failed in this case. It relied on practitioners to check back through progress notes to ensure there was nothing outstanding to be addressed. It was held that the absence of notes documenting such review on subsequent presentations by Mr Impu indicated that the system failed.⁶

The court referred to evidence given by Dr Janusic that 30% - 50% of patients failed to attend their appointments at the physician clinic. She also gave evidence that a lot of CAACI’s patients had a great many distractions and social problems. The court’s reference to this evidence appears to indicate that it placed importance in the fact that CAACI was aware of the difficulties that many of its patients encountered in attending appointments at the clinic. Accordingly, this made the follow-up systems for these attendees of even greater importance than at medical clinics that operate in different social environments.

Dr Boffa’s duty of care

It was found that CAACI was directly and vicariously liable in respect of a duty of care owed to patients.⁷ Accordingly, CAACI was potentially liable for any negligence of Dr Boffa.

The court confirmed that the law relating to the duty of care owed by a medical practitioner is set out in *Rogers v Whitaker*⁸. It was accepted that the standard of care and skill owed by Dr Boffa was that of an ordinary skilled general medical practitioner specialising in the provision of health

⁵ [2008] NTSC 47 at 213

⁶ [2008] NTSC 47 at 208

⁷ [2008] NTSC 47 at 158.

⁸ (1992) 175 CLR 479 at 483, Mason CJ, Brennan, Dawson, Toohey and McHugh JJ

care to aboriginal people in Central Australia. The court found that the course of action arranged by Dr Boffa following his assessment of Mr Impu was reasonable.⁹

Further, it was found that it was not Dr Boffa's responsibility to follow up Mr Impu upon his failure to attend the arranged appointments. The court distinguished previous decisions in which doctors have been found to be negligent in cases where they did not have any system in place to ensure follow ups.¹⁰ In this case there was a system implemented by CAACI to follow up patients. However, the system had failed.

Accordingly, the court was not satisfied on the balance of probabilities that Dr Boffa was negligent in his treatment or follow up of his patient and the claim for damages against him was dismissed.¹¹

Causation

It was argued by the Defendants that Mr Impu had solely caused his death by exercising a right to allow his ischaemic heart condition to take its course. However, the court found that the deceased's various presentations to medical practitioners following his appointment with Dr Boffa indicated a concern for his own health. Had the doctors mentioned the possibility of ischaemic heart disease or queried why he had not completed the follow up tests he would have undertaken the tests and his condition would have been treated.¹²

Contributory negligence

However, His Honour did find that Mr Impu owed a duty to exercise reasonable care for his own safety, health and well-being and that he failed in his own interests to attend either appointment arranged by Dr Boffa or raise the issue of these tests when he subsequently attended CAACI. As such, there was a 50% discount in the award of damages to the Plaintiff for Mr Impu's contributory negligence.¹³

The finding of the court placed a significant amount of personal responsibility upon Mr Impu to take care for his own health. In doing so, the court gave weight to Mr Impu's ability to understand the advice given to him. Thus, in assessing the culpability of an injured party, the court will consider the level of education and sophistication of the particular patient.

Damages

The court awarded damages for loss of dependency, household services and solatium and consortium for the Plaintiff and her children in the amount of \$236,972, including a 50% reduction for contributory negligence.

Interestingly, in calculating the dependency claims, the court awarded a loading for positive contingencies for past and future earnings of Mr Impu. The court relied on a number of factors,

⁹ [2008] NTSC 47 at 152.

¹⁰ [2008] NTSC 47 at 217 – 220 (See *Tai v Hatzistavrou* [1999] NSWCA 306 and *Kite v Malycha* (1998) 71 SASR 321).

¹¹ [2008] NTSC 47 at 221.

¹² [2008] NTSC 47 at 224.

¹³ [2008] NTSC 47 at 260 – 262 (See the principles applied in relation to the issue of contributory negligence)

including the fact that the deceased was moving into a more mature age group and he was likely to become more settled and have increased opportunities for employment.¹⁴

Conclusion

The decision sends a strong warning to health care providers that they must not only provide reasonable medical advice and treatment but their administrative practices must ensure that patients do not slip between the cracks. This is particularly the case where the administrative systems put in place take responsibility away from individual doctors. However, the court was also clear in stating that it is not only health care providers that have a responsibility in ensuring that individuals receive appropriate and diligent services, but individuals also have a significant part to play in ensuring that their medical needs are attended to. In future cases it will be interesting to see the weight given to a claimant's level of education and sophistication for the purpose of assessing the degree of contributory negligence.

¹⁴ [2008] NTSC 47 at 269