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## Ambulance Service of NSW v Worley

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## **Editorial**

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### **Ambulance Service of NSW v Worley: an Editorial**

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The case of Ambulance Service of New South Wales versus Worley presented by Michael Eburn in this issue, provides a very interesting and important reflection on the interaction between the legal process and the clinical process determining appropriate patient care. The case and the legal arguments are well presented in the article. This case turns the spotlight on a number of very significant areas in relation to clinical practice and clinical governance of ambulance services.

The legal decision derived from a retrospective process in a court of law has the ability to inform clinical practice on appropriate treatment. Expert opinion derived in a court of law has both the benefits of time to evaluate all evidence in a considered judgment and the deficits of being removed from actual clinical practice.

A benefit was illustrated by the appreciation of the progressive change in attitude in subsequent additions of key textbooks documented in the proceedings. A decrease in recommended adrenaline IV dose and a preference towards intramuscular adrenaline use for anaphylaxis is described. Those responsible for clinical governance of ambulance services should be reminded that clinical attitudes change and evolve with new evidence as it becomes available and that a guideline that was state of art when written may become out of date. A deficit of considering the case in legal isolation separate from clinical practice is also illustrated in that the initial ruling quoted a supposed overdose of adrenaline at 4 mg whilst the actual clinical dose used was 400 µg. An unfamiliarity with medical dosage calculation has the potential to influence court recommendations.

This case has been pivotal in precipitating change in ambulance clinical guidelines across the country. It has prompted a review of adrenaline administration in anaphylaxis that has not only seen a uniform reduction in dose across the country but a previously unknown degree of consistency between the various ambulance services' approaches. This very significant silver lining paves the way for increasing uniformity of clinical guidelines between various ambulance services.

The second important impact of this case is that it acts as a catalyst for those involved in clinical governance of ambulance services to ensure that their existing guidelines have kept pace with changes in medical attitude and treatment as they occur. In personal communication with Dr Michael Flynn who was the Medical Director of the ambulance service at the time he reflects that "this case has huge implications in the area of evolving concepts and expectations in clinical governance and is of great relevance to those with a responsibility to advise ambulance services on current appropriate clinical practice".

This case has the potential to be a significant catalyst for change in attitude to clinical governance not only in this country but internationally.