



Traps for plaintiffs in medical negligence litigation

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Throughout the late 1990s a series of high profile medical negligence cases worth millions of dollars combined with sensational media reporting, created the perception that there had been an “explosion” in medical negligence litigation. As a result of this perception, some medical health professionals resorted to practicing defensive medicine, subjecting their patients to unnecessary tests and refusing to take on patients at high risk of adverse outcomes.

In addition, increases in medical insurance premiums for doctors created anger in the profession.

Against the background of this climate of fear, New South Wales Parliament enacted the Civil Liability Act 2002 which now determines the extent of liability in the tort of negligence in New South Wales, including liability for medical negligence.

One of the aims of the Civil Liability Act was to further reduce the scope of the liability of medical practitioners.

It is true that the tort of medical negligence had expanded in its scope in a range of ways including the following:

- Holding off duty medical practitioners to the standard of care of the “reasonable” practitioner when rendering assistance to someone while off duty.
- Denying medical practitioners the entitlement to rely on *the Bolam principle* (under which practitioners would escape liability they could provide evidence of a body of practitioners who would have acted similarly in the circumstances) in situations of a negligent failure to warn of a risk.
- Liability for failing to warn a patient of a medical risk where the Plaintiff could show that he or she would not have undertaken the treatment had the warning be given, despite evidence that the risk was remote and most practitioners would not have warned of it.

- The awarding of damages for the cost of raising children in matters where sterilisation procedures had been carried out incorrectly.
- General increases in the range of damages being awarded for care in medical and other personal injury matters.

Much of the “panic” however was unfounded and unsupported by statistics.

Section 50 of the *Civil Liability Act 2002*:

The introduction of a modified *Bolam principle*

Prior to the introduction of the *Civil Liability Act* liability of medical professionals was decided with reference to a principle called the “Bolam principle”. This principle was articulated in *Bolam v Friern Barnet Hospital Management Committee* [1956] 1 WLR 582, an English case decided in 1957 and adopted in Australia.

Determination of the standard at which medical practitioners must carry out their professional responsibilities was put into the hands of medical practitioners rather than the judiciary. A “peer” opinion.

The principle dictates that “a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice”.

The principle was refined in *Rogers v Whittaker* (1992) 175 CLR 479 where the High Court of Australia denied a medical practitioner reliance on *the Bolam principle* despite overwhelming evidence to the effect that the risk he had failed to warn his patient of, was not a risk that most medical practitioners would have felt obliged to raise with their patients. The Court accepted that *the Bolam principle* was relevant to diagnosis and treatment but in relation to a failure to warn of risk, it determined that the ultimate decision laid with the Court “after giving weight to the paramount consideration that a person is entitled to make his own decisions about his life”.

The rejection of *the Bolam principle* in this case hinted at a general erosion of the protections hitherto enjoyed by the medical profession.

Section 50 of the *Civil Liability Act* incorporates a modified form of *the Bolam principle* and operates it as a defence available to medical practitioners.

50 Standard of Care for professionals

1. A person practicing a profession (a professional) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner (at the time the service was provided) that was widely accepted in Australia by peer professional opinion as competent professional practice.
2. However, peer professional opinion cannot be relied on for the purposes of this section if the Court considers that the opinion is irrational.
3. The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent anyone or more (or all) of those opinions being relied on for the purposes of this section.
4. Peer professional opinion does not have to be universally accepted to be considered widely accepted.

This section clearly and explicitly reinstates *the Bolam principle* to the benefit of medical practitioners although it specifically does not relate to the duty to warn of a risk and does not apply to an opinion if the Court deems it to be irrational. It also protects the principle from further erosion.

This is a defence and as such must be pleaded by a Defendant before it can be relied upon.

It is prudent for Plaintiff practitioners to file a Reply relying on S50 (2) or irrationality.

SECTION 5D CIVIL LIABILITY ACT

Failure to warn

Most medical treatments and procedures come with an element of risk.

Day in day out, patients submit themselves to general anaesthesia and surgery, serious and cosmetic, despite receiving warnings from their medical treatment providers that it is possible but not likely that a range of adverse outcomes from scarring to death may occur.

If a medical practitioner fails to provide a patient with information in relation to risks and one of those risks or adverse outcomes eventuates despite reasonable care being taken by the practitioner, human nature dictates that a patient genuinely believes that they would not have had the procedure had they known of the risk of the adverse outcome which did, in fact, eventuate.

In *Christopher Rogers v Maree Whitaker* the Plaintiff, who was blind in one eye, underwent a surgical procedure which carried a very remote risk of loss of the vision in her good eye.

She was not warned of this risk. It did in fact occur and she was left totally blind. The Plaintiff gave evidence which persuaded the Court that, had she been advised of the risk of losing her remaining vision, she would not have proceeded with the surgery.

She succeeded.

Between 1992 (*Rogers v Whitaker*) and the enactment of the *Civil Liability Act* there was an increase in litigation by Plaintiffs founded on allegations that they were not warned by their treating medical practitioners of risks which did in fact eventuate.

Section 50 of the *Civil Liability Act* makes it more difficult for a Plaintiff to establish causation in failure to warn cases. In other words, the section is specifically intended to counteract the natural tendency of injured patients to give evidence that they would not have had the procedure that caused their injury had they known of the risk.

5D General Principles

5D(3): If it is relevant to the determination of factual causation to determine what the person who suffered harm would have done if the negligent person had not been negligent:

- (a) the matter is to be determined subjectively in light of all relevant circumstances, subject to paragraph (b), and
- (b) any statement made by the person after suffering harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest.

In other words, if the negligence complained of is a failure to warn a patient of a risk associated with medical treatment and that risk does eventuate, the Plaintiff is unable to give evidence in their own case that they would not have had the procedure if they had been warned of the risk.

The Court is left to determine this issue after consideration of other relevant evidence such as the likelihood of the risk occurring, the nature of the risk, and the other circumstances of the case.

To illustrate:

If, for example, the risk that eventuated was total blindness and the prospects of that risk occurring in a cosmetic procedure were 50% it is likely that the Court would find that the injured patient would not have undergone the procedure had they been warned of the risk.

Conversely, if the treatment provided to the patient was of the lifesaving nature, for example, removal of an aggressive malignancy and the risk which was not warned of but eventuated was of keloid scarring, then it is unlikely the Court would find that the Plaintiff would not have undergone the lifesaving surgery in that circumstance.

This provision was intended to make the running of failure to warn cases very difficult. It has succeeded.

In addition to the legislative pitfalls outlined above, due to the heavily defended nature of the jurisdiction, the vagaries of the human body and the imperfect nature of medical science, it is not possible to take a broad-brush approach in medical negligence litigation. A very detailed analysis of the medical issues is required particularly in the area of causation at a very technical level.

The choosing of experts with clout is important.

Medical insurers are unlikely to offer commercial settlements so every matter should be prepared on the assumption it may have to be fully litigated.

**PETERSON v SOUTH
EASTERN SYDNEY
ILLAWARRA AREA HEALTH
SERVICE & ELLIOTT [2010]
NSWDC 114 (24 June 2010)**

**Plaintiff failed on breach of duty
& causation**

Mr Peterson sustained a serious fracture to his right ankle and lower leg in circumstances which were not compensable.

An initial attempt was made by those treating him to surgically reduce the many fragments involved.

Over a period of months, the Plaintiff's fractured bones failed to repair themselves. They either did not unite or exhibited "delayed union". There was some dispute in relation to interpretation of radiological films in this regard.

For a period of approximately 8 months the Plaintiff periodically attended the Fracture Clinic at Wollongong Hospital for management and review, in order to check on the progress of the healing of his fractures. On those occasions the state of the healing of the fractures was assessed by various Orthopaedic Registrars at the clinic.

After 8 months, Dr Elliott formed the view that the Plaintiff's injury was not going to heal and the Plaintiff was referred to another surgeon who recommended further surgical correction of the problem.

One thrust of the Plaintiff's case was that those treating him had been too conservative in their approach and surgery should have been recommended sooner.

The Plaintiff further alleged that failure to intervene surgically at an earlier time had resulted in a less satisfactory outcome and greater continuing disabilities.

The Plaintiff obtained some expert support for this proposition and called evidence that the course of treatment provided to the Plaintiff by his treating surgeon was below the expected standard of care.

Breach of duty of care:

Levy DCJ found that the Plaintiff had not established breach of duty of care.

The question of whether or not the Defendants were negligent required determination in the context of Section 50 of the *Civil Liability Act* which provides that professional services do not incur a finding of negligence if it is established that at the relevant time the professional concerned acted in a manner that was widely accepted in Australia by peer professional opinion as competent professional practice. That principle is subject to the proviso that peer professional opinion can not be relied upon as a defence if the opinion concerned is considered by the Court to be irrational: s 50 (2) of the *Civil Liability Act*.

The Defendants called expert evidence from 2 well regarded medical practitioners to the effect that the course of treatment decided on by Dr Elliott was well established and competent.

The Court further noted that one must not be influenced by hindsight or outcome bias ie. one must, so far as is possible, put aside knowledge on the part of an expert witness of an adverse outcome that influences subsequent liability analysis. Dr Elliott gave reasons for not recommending earlier surgical intervention including presence of infection and his conservative approach.

The Plaintiff argued that the fact that conservative treatment had not worked was evidence of negligence. The Judge found that the Plaintiff's argument was driven by impermissible considerations of hindsight.

The Plaintiff alleged that the failure by the Defendants to advise the Plaintiff that early surgical intervention was available and to implement such early surgical intervention had resulted in the disadvantages of delay including mal-union due to uncorrected fracture site, angulation and ankle joint stiffness.

The Judge found that the reasons which Dr Elliott considered to be contradictions for not operating on the Plaintiff were not refuted as being irrelevant. Further, he found that the reasons given by Dr Elliott for not operating earlier did not appear to be inherently unreasonable, illogical or irrational. The defence under s50 was established.

Causation:

To succeed on the issue of causation a Plaintiff is firstly required to establish negligence and, secondly, show that the negligence complained of either caused or materially contributed to the harm for which damages were claimed.

The Judge in this matter made some findings in relation to causation which were ultimately not relevant because he did not find breach of duty of care.

The Plaintiff's initial injuries were very serious.

The Judge found that he had been unable to demonstrate through evidence, that any different medical outcome would have occurred even if the second surgery had been performed sooner.

A reading of the judgment shows the level of detail and forensic analysis involved in consideration of the "medical" issues.

There was disagreement over interpretation of radiological films and other very technical details. Plaintiffs cannot take a broad-brush approach to the medical evidence.

Contributory negligence:

The Defendants alleged that the Plaintiff was partly responsible for his own injuries by failing to heed the doctor's advice to give up smoking.

This is an issue often raised in medical negligence matters particularly where the Plaintiff's complaints involve wounds which have not healed or post-operative infection has occurred.

The Court found that it was not enough for a Defendant to raise the issue of smoking. It was incumbent upon the Defendants to provide evidence of the fact that the Plaintiff's failure to cease smoking had a material contributing causative impact on the delay of bone union in this particular case.

ATHANASIADIS v LIKOS [2010] SADC 85

In this matter, the Plaintiff's wife died of gallbladder cancer in November 2001. Gallbladder cancer is a rare cancer that does not generate symptoms until it is in its terminal stage. Earlier diagnosis generally occurs as an incidental finding arising from the diagnosis and treatment of another condition, such as gallstones.

The Plaintiff's claim was founded on an allegation that his wife was exhibiting symptoms consistent with suffering from gallstones prior to the development of her cancer, that the symptoms of gallstones should have been followed up by the treating practitioner, and that such treatment would have resulted in detection of the cancer and the Plaintiff's survival.

The Judge found in favour of the Defendants in relation to both breach of duty and causation.

The Court held that the Plaintiff had not established a factual basis upon which it could be said that a reasonably competent medical practitioner would have investigated the possibility of gallstones prior to September 2001.

In relation to causation, the Court further held that even had the Defendant diagnosed the gallstone problem the Plaintiff had not established that an earlier diagnosis of gallstones would have resulted in the removal of the gallbladder and subsequent avoidance of the Plaintiff's death.

Whilst this matter was a South Australian matter and therefore not subject to the provisions of the *Civil Liability Act*, it is another example of the rigour with which a Plaintiff's case can be tested in this area.

**HOLLIER v SUTCLIFFE [2010]
NSWSC 279 SUPREME
COURT OF NEW SOUTH
WALES 23 APRIL 2010,
HULME J**

**Consideration of claims for
mental harm.**

The Plaintiff in this matter sought damages against a doctor who inserted an Implanon contraceptive implant into her left upper arm on 16 October 2006. She alleged that the doctor incorrectly inserted the implant and then failed to take the appropriate action consequent upon the error.

The main issues were as follows:

1. Was the Implanon implant incorrectly inserted thereby breaching the Defendant's duty of care owed to the Plaintiff?
2. If so, did the breach cause the Plaintiff's physical and mental trauma?
3. Is there a duty of care in relation to mental harm (Section 32 *Civil Liability Act 2002*)?
4. How does one measure damages?

The Implanon device was inserted in October 2006. Shortly after the insertion of the Implanon rod into the Plaintiff's upper arm she developed pain, tightness and discomfort in her left arm, swelling in the armpit region, bruising and lumps in her left armpit and a spasm and tight feeling in her left leg.

Her condition deteriorated until she could hardly walk and she presented at the Casualty Department at Liverpool Hospital.

The next day she returned to the Defendant's rooms, received a local anaesthetic and the implant was removed during a procedure which took 10 to 15 minutes. The removal procedure was painful and stitches were required.

There was a factual dispute between the Plaintiff and the Defendant in relation to the way the insertion procedure was carried out.

Liability experts essentially agreed that if the insertion procedure had occurred in the way that the Plaintiff described that the Defendant had used an incorrect technique but, if the Defendant had carried out the procedure as she described then it was entirely in accordance with competent professional practice (see Section 50 of the *Civil Liability Act 2002*).

The determination of whether or not the Defendant was in breach of her duty of care therefore, in this particular case, turned upon whose version of events the Judge accepted.

The Judge ultimately accepted the evidence of the Defendant and found against the Plaintiff in relation to breach of duty of care.

In relation to causation, the Plaintiff claimed that the Defendant's negligence had given rise to a pain syndrome with depressive reaction and a range of symptoms including anxiety and depressed mood. A joint expert report was obtained which concluded on the question of causation as follows:

“As to the relevant weight of each of these contributing factors there was a spread of opinion amongst the participants in the joint conference. Some participants considered that the insertion of the Implanon device triggered a cascade resulting in the current reported patterns of symptoms and disabilities. Others felt that the effects of the insertion of the Implanon device were relatively insignificant when considering the nature and subsequent events and the magnitude of the response. Hence, greater emphasis was placed by those observers on the vulnerability factors.”

The Plaintiff had argued that she had a chronic pain condition in her arm and further argued that, in the absence of any other explanation, it followed that the insertion of the Implanon device was the cause of the pain given that it had arisen immediately after the insertion procedure.

The Judge found that the mere coincidence of the two events occurring (the implantation and the experience of pain) did not necessarily establish causation between breach and harm such as to then put a burden on to the Defendant to prove otherwise. In this case, there was no evidence of physical damage caused by the implantation procedure and it was also noted that it was common ground that the Plaintiff was not malingering, in that she genuinely believed she suffered the harm of which she complains.

A discussion was had in relation to **Section 32 of the Civil Liability Act** which reads:

:

32 Mental harm – duty of care

- (1) A person (“the defendant”) does not owe a duty of care to another person (“the plaintiff”) to take care not to cause the plaintiff mental harm unless the defendant ought to have foreseen that a person of normal fortitude might, in the circumstances of the case, suffer a recognised psychiatric illness if reasonable care was not taken.
- (2) For the purposes of the application of this section in respect to pure mental harm, the circumstances of the case include the following:-
 - (a) whether or not the mental harm was suffered as a result of a sudden shock;
 - (b) whether the plaintiff witnessed at the scene a person being killed, injured or put in peril;
 - (c) the nature of the relationship between the plaintiff and any person killed, injured or put in peril;
 - (d) whether or not there was a pre-existing relationship between the plaintiff and the defendant.

(3) For the purposes of the application of this section in respect of consequential mental harm, the circumstances of the case include the personal injury suffered by the plaintiff.

(4) This section does not require the Court to disregard what the defendant knew or ought to have known about the fortitude of the plaintiff.

Section 27 provides some definitions including:

Consequential mental harm means mental harm that is a consequence of a personal injury of any other kind.

Mental harm means impairment of a person’s mental condition.

Pure mental harm means mental harm other than consequential mental harm.

Given the findings of the Judge that no physical injury was established the Plaintiff’s contention that she suffered consequential mental harm was not established.

This involves consideration of whether or not the Plaintiff was a person of normal fortitude.

The High Court in the matter of *Tame v New South Wales; Annetts v Australian Stations Pty Ltd* [2002] HCA 35; 211 CLR 317, Gleeson C J spoke of "normal fortitude" thus:

"The variety of degrees of susceptibility to emotional disturbance and psychiatric illness had led Courts to refer to "a normal standard of susceptibility" as one of a number of "general guidelines" in judging reasonable foreseeability.

This does not mean that Judges suffer from the delusion that there is a "normal" person with whose emotional and psychological qualities those of any other person may readily be compared. It is a way of expressing the idea that there are some people with such a degree of susceptibility to psychiatric injury that it is ordinarily unreasonable to require strangers to have in contemplation the possibility of harm to them, or to expect strangers to take care to avoid such harm. Such people might include those who, unknown to a Defendant, are already psychologically disturbed. That idea is valid and remains relevant, even though "normal fortitude" can not be regarded as a separate and definitive test of liability."

In this case the Plaintiff underwent a relatively simple procedure for the insertion of a contraceptive implant. The Judge asked himself the question "*ought the Defendant have foreseen that a patient of normal fortitude might suffer a recognised psychiatric illness if she did not take reasonable care in carrying out the procedure*".

The Judge concluded that the Defendant ought not to have foreseen that a recognised psychiatric illness might be suffered.

**MARKO v FALK [2008]
NSWCA 293 NEW SOUTH
WALES COURT OF APPEAL
10 NOVEMBER 2008
McCOLL, CAMPBELL, BELL
JA**

**Weight given to the Defendant's
peer expert opinion.**

This is an interesting case where a surgeon performed 3 procedures: an endoscopy, a colonoscopy and a laparoscopic cholecystectomy under one general anaesthetic on a patient that was terrified of anaesthesia.

Whilst performing the endoscopy of the upper intestinal tract the Defendant discovered the presence of a polyp in the upper duodenum, a rare condition almost always a precursor to a malignancy. The Defendant made the decision, whilst the patient was anaesthetised, to remove the polyp using the endoscope and diathermy. Unfortunately the diathermy damaged the duodenum which ultimately perforated resulting in sepsis and serious injury.

Amongst other things, the Plaintiff alleged that the Defendant should not have removed the polyp whilst she was anaesthetised, should have withdrawn the endoscope and advised her of her options in relation to later surgery including laparoscopic removal of the polyp and open surgical removal of the polyp.

Each alternative procedure had its own set of risks but were perhaps not as risky as the endoscopic removal of the polyp that was performed.

The Plaintiff's complaints pre-dated the *Civil Liability Act* so liability was considered with reference to *Rogers v Whitaker* (1992) 175 CLR 479 at 483, which defined the duty of a medical practitioner as a "*single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment*" the standard being that of the "*ordinary skilled person exercising and professing to have that special skill*".

In this case, the skill of a surgeon specialising as an upper gastrointestinal surgeon endoscopist practicing at a tertiary referral centre.

Consideration of *the Bolam principle* was also required.

The Plaintiff at trial, partly in desperation, ran a *res ipsa loquitur* case ("the matter speaks for itself). The Plaintiff's argued "*the way in which this procedure was carried out just speaks negligence on the part of the Defendant*".

It would be a very unusual for a medical negligence case to be won on the doctrine of *res ipsa loquitur* which can be defined as an "*inference which the reasonable man in knowing the facts would naturally draw*" and, that is, in most cases for two reasons:

- (i) because the control over happening of such an event rests solely with the Defendant, and

(ii) that in the ordinary experience of mankind such an event does not happen unless the person in control has failed to exercise due care.....

An ordinary Judge would be unlikely to have sufficient knowledge of surgical procedures to draw such an inference.

Res ipsa loquitur may be an appropriate argument however in a matter where, for example, a Plaintiff woke up after general anaesthesia on the floor with a broken leg. Even though that Plaintiff would have no direct evidence of how the Defendant behaved, it is likely that the Plaintiff would establish that such an injury would not have occurred without negligence.

Evidence submitted at trial in the *Marko v Falk* matter included opinions that injuries such as that sustained by the Plaintiff could have occurred in the course of polypectomy without negligence on the part of the surgeon.

At trial, the Defendant's experts gave evidence that the decision to perform endoscopic removal of the polyp was a matter of clinical judgment based on what he had observed, in the light of his skills and experience.

The trial judge concluded that the Defendant's decision to remove the polyp endoscopically involved a reasonable exercise of his clinical judgment based on his observations, skills and experience.

The Judge found against the Plaintiff as follows:

"In my opinion reasonable care did not require the Defendant to advise open surgery, or laparoscopic surgery in preference to endoscopic snaring. The laparoscopic procedure was technically difficult and there was no clear cut advantage in having open surgery as opposed to endoscopic surgery where the latter was performed by an experienced and skilled endoscopist which the Defendant, in my opinion, undoubtedly was. All procedures involve risks. Professor Morris indicated that in addition to scarring with open surgery there was a risk of wound dehiscence, peritonitis and sepsis as well as anaesthetic risks. Associate Professor Bolin was of the opinion that risks of surgical removal of a duodenal polyp were less than an endoscopic polypectomy: unless you practice in a centre where there is a huge experience in removing these things and you act as a tertiary referral centre, so patients are sent from all around the State or from other countries.

The Defendant, of course, performed polypectomies in tertiary referral circumstances with referrals of difficult cases to him from Sydney and throughout the State. Associate Professor Bolin was unaware that the Defendant operated in such a centre. The difference between the experts on this question was primarily one dependant upon their area of practice.

As Professor Williamson accepted, it was a matter for clinical judgment as to which procedure should be performed.

In my opinion it is probable the Plaintiff would have instructed the Defendant to proceed with an endoscopic snare removal which would entail the same risks as if the procedure had been carried out initially. Deferring the procedure would have simply exposed the Plaintiff to additional risks involved in taking a biopsy during the first procedure".

The appeal

The Plaintiff appealed on the following grounds:-

1. His Honour erred in finding the Respondent did not breach his duty of care or contract to the Appellant by preferring polypectomy to open or laproscopic surgery.
2. His Honour erred in failing to find the Respondent breached his duty of care or contract to the Appellant by removing large sessile polyp by polypectomy.
3. Alternatively to ground 2, His Honour erred in failing to find the Respondent breached his duty of care or contract to the Appellant in that he removed a large sessile polyp;
 - (i) without having first injected a saline solution; and/or
 - (ii) without having first secured adequate vision of the polyp's far side; and/or

(iii) whilst engaged in the Appellant's colonoscopy procedure; and/or

(iv) without inserting a drain at the same time.

4. (a) His Honour erred in not (or not adequately) taking into account evidence of the Respondent in cross examination which included the large sessile polyps were generally too hazardous to remove by polypectomy;

(b) His Honour erred in mistaking the evidence of the Respondent in cross examination by not assigning it to the categorisation of concession or admission.

5. His Honour erred in his assessment of damages.

The Plaintiff on appeal again agitated the *res ipsa loquitur* claim which had been rejected by the primary Judge and Mr Neil for the Appellant submitted that the evidence "bespoke negligence".

The Appeal was unsuccessful.

The Court of Appeal went on to say:

"The matters to which reference has been made indicate that the evidence of medical practitioners is of very considerable significance in cases where negligence is alleged in diagnosis or treatment.

However, even in cases of that kind, the nature of particular risks and their foreseeability are not matters exclusively within the province of medical knowledge or expertise. Indeed, and not withstanding that these questions arise in a medical context, they are often matters of simple common sense".

Rogers v Whittaker confirms that the standard of care required by doctors is not to be determined solely or even primarily by reference to the practice followed or supported by a reasonable body of opinion by the profession. Specifically in relation to warnings of risks, in *Marko v Falk*, the circumstances in which a Court may substitute its own opinion are briefly addressed in the following terms in the Court of Appeal:

"Mr Neil submitted that Rogers v Whittaker supported the proposition that if all members of a particular profession were doing something that was not in accordance with what the Court considered to be careful practice, then the Court should say so".

"That submission was pitched at such a high level of generality as to be meaningless. It fails to recognise the careful distinction all members of the High Court drew in Rogers v Whittaker between diagnosis and treatment and warning of risks. Mr Neil did not suggest any sensible route by which the Court could impose a view as to careful practice contrary to the medical opinions called on behalf of both parties.

Mr Neil could not refer the Court to any case since (or before) Rogers v Whittaker in which the Court had taken the course he propounded in a case which involved clinical judgment in an operational context".

"In my view this was a case where the plurality views in Rogers v Whittaker as to the often decisive role professional opinion may play has strong resonance".

The Plaintiff may have felt confident in this matter given the terrible injury arising out of the procedure which was done without consent but the Defence available under s50 of the *Civil Liability Act* succeeded.

The case should perhaps have been run as a "trespass to the person" case.

**ALBRIGHTON v ROYAL
PRINCE ALFRED HOSPITAL
[1980] 2NSWLR 542**

Overseas expertise

In the matter of *Albrighton v Royal Prince Alfred Hospital* [1980] NSWLR 542 the Trial Judge refused to permit expert evidence from a neurologist practicing in London in regards to techniques applied by a neurologist practicing in Sydney.

The Trial Judge rejected the evidence on the basis *inter alia* that the expert was not a Sydney practitioner.

On appeal in that matter, the Court of Appeal had a different view stating:

"It is also, in my view, a wrong assumption that a jury should be directed that, if what is charged as medical negligence is shown to have been in accordance with the usual and customary practice and procedure then prevailing in what was called a particular "medical community", they cannot find negligence. This, in my opinion, is plainly wrong because it is not the law that, if all or most of the medical practitioners in Sydney habitually fail to take an available precaution to avoid foreseeable risk of injury to their patients, then none can be found guilty of negligence....."

"Local practice provides no basis for the exclusion of evidence by experts lacking local experiences to the correct way in which a particular treatment should be performed or whether a particular treatment should be given at all".

The decision illustrates further erosion of the *Bolam principle* and is of assistance to Plaintiffs.

**MELCHIOR v SYDNEY
ADVENTIST HOSPITAL
LTD [2008] NSWSC 1282
SUPREME COURT OF NEW
SOUTH WALES 9 DECEMBER
2008, HOEBEN J**

Defendants easy access to Senior Medical Practitioners for expert opinion can be evidence of an “uneven playing field”.

No due regard given to the scope of the Defendant’s duty.

This claim was a claim brought by the widow, children and mother of Mr Mark Melchior who died of a pulmonary embolism on 10 June 2004 after an operation to repair his Achilles tendon.

The second Defendant, Dr Newman, performed the surgery at the first Defendant’s hospital.

The Plaintiffs alleged that as a result of the failure on the part of the Defendants to administer an anti-coagulant in the immediate post-operative period, Mr Melchior developed a deep vein thrombosis and ultimately a fatal pulmonary embolus.

The Plaintiffs took comfort from an obvious breach on the part of the operating surgeon, Dr Newman.

On the operation chart under the heading “post operative instructions” Dr Newman wrote the following in an abbreviated form:

“Elevate the foot, administer intravenous antibiotics overnight, the staff to perform distal observations on the record and Clexane”

Clexane is an anticoagulation agent.

As a result of an oversight, which he conceded during his evidence, he did not make any entry for administration of Clexane on the Medication charts so it was not in fact administered.

It had been his **intention** that Mr Melchior receive an additional single dose of Clexane on the morning after his surgery.

The difficulty the Plaintiffs had however was that, despite the admitted breach, they were unable to establish that even if the single dose of Clexane had been administered after his surgery it would have prevented the ultimate development of his deep vein thrombosis.

There was no evidence that a single dose of Clexane post-operatively would have made a difference to a patient’s risk of developing thrombo-embolic disease.

The doctor did not see any need to prescribe Clexane post-operatively after discharge because Mr Melchior had not demonstrated any significant risk factors that would have required such a regime. Despite the fact that he did develop a deep vein thrombosis, Mr Melchior was actually a low risk a patient for that complication.

The experts for both parties attended a conclave and submitted a joint report.

The Plaintiffs relied upon a General Surgeon, Dr Conrad, and Physician, Dr Benson.

The Defendants called very senior doctors and Professors specialising in foot and ankle surgery, vascular medicine and vascular surgery.

The Judge noted the level of expertise of the Defendants’ experts was significantly higher than that of the Plaintiffs.

This can be a problem for Plaintiffs. Defendant's insurers obviously have access to a broad range of medical practitioners willing to provide their opinion and Plaintiff lawyers should be very wary of relying on opinions from doctors prepared to give them, whilst perhaps not being qualified to do so.

The Defendants' experts provided the opinion that it was not standard practice to administer Clexane as a prophylaxis to prevent DVTs because, as a coagulation agent, Clexane brings with it its own set of risks including post-operative hemorrhaging. It would generally only be administered where a patient had a particular risk of developing a DVT which this patient didn't.

On the fifth day of the hearing the Plaintiffs foreshadowed an amendment to the Statement of Claim and a desire to include an allegation of failure to warn pleaded as "failed to warn the deceased adequately or at all about the prophylactic treatment options available to him and, in particular the use and dosage of Clexane when the Defendant knew or ought to have known that the deceased was at risk of forming a blood clot or DVT as a result of the operation which could develop into a fatal pulmonary embolism".

The Judge considered that the substance of the proposed amendment was not actually a failure to warn but rather a failure by Dr Newman to explain to the deceased the advantages and disadvantages of using Clexane.

The rationale for the Plaintiffs phrasing their amendment as a failure to warn was an attempt to activate s5P of the *Civil Liability Act*, and avoid the operation of s5O of the *Civil Liability Act*. The Plaintiffs' application was refused.

S5P of the Act specifically states that a Defendant cannot rely on peer professional opinion to defend a case where he failed to warn of a risk.

In relation to the content of the duty of the care, the Court applied the principles of *Rogers v Whitaker* and defined the scope of Dr Newman's duty as that of a surgeon specialising in foot and ankle surgery in Australia in May 2004.

The Defendant pointed out that, implicit in the Plaintiff's case, was the argument that the scope of Dr Newman's duty included an obligation to administer Clexane for an appropriate period following the operation.

The Plaintiffs were criticised for the failure to grapple with the content and scope of the Defendant's duty in any of their submissions.

The Plaintiffs' submissions assumed a duty in general terms without seeking to define it in any way. The Plaintiffs sought to find a breach of duty through an analysis of the fact that development of a DVT was a foreseeable risk and that the appropriate response to that risk was to prescribe Clexane.

They did not make the initial analysis of the scope and content of the doctor's duty and the Court found that the approach of the Defendants was correct in this regard. The first questions to be determined was whether the duty of care which Dr Newman undoubtedly owed to the deceased included an obligation to administer Clexane. The Court found that the duty of care did not include that obligation.

In relation to breach of duty the Court found that the only breach of Dr Newman's duty was a failure on his part to ensure that a single dose of Clexane was administered following the operation.

There was no evidence to support the submission that that breach had, in any way, caused the death of the Plaintiff.

The Plaintiffs failed to meet the test of factual causation. The proposition that the single dose of Clexane that Mr Melchior missed out on would have saved his life was never put to any of the doctors. The submission was based on speculation not inference as the evidence did not establish when the clot formed and when it broke off.

The medical evidence was all one way on this point and the medical experts concurred that one or two doses of Clexane given at the time of the operation would not have prevented the development of the fatal pulmonary embolism 27 days later.

The Court considered the High Court decision in the matter of *Rosenberg v Percival* [2001] HCA18, (2001) 205 CLR 434 Gleeson CJ at 16:

“In the way in which litigation proceeds, the conduct of the parties is seen through the prism of hindsight. The foreseeable risk has eventuated and harm has resulted. That particular risk becomes the focus of attention. But at the time of the allegedly tortious conduct, there may have been no reason to single it out from a number of adverse contingencies or to attach to it the significance it later assumes”.

The Court was not persuaded that, after consideration of the issues above, the failure by Dr Newman to administer Clexane 7 to 10 days following the operation constituted a failure to comply with the appropriate professional standards.

The Court went on to say that if they were wrong in that conclusion that the Defendant had clearly established the defence allowed to them under s50 of the *Civil Liability Act*.

The Plaintiffs failed dramatically on every front.

The decision to run the case may have been based on the obvious breach which did occur and the size of the damages at stake.

**CLOTHIER v DR FENN &
GREATER SOUTHERN AREA
HEALTH SERVICE [2010]
NSWDC 96**

This case concerns aspects of the recent High Court authority *Tabet v Gett* [2010] HCA12 which reinforced that a Plaintiff must be able to satisfy the Court that:

1. The Defendant was factual in any negligence, in that their treatment fell below the required standard of care; and
2. The negligence was in fact more probably than not the cause of the Plaintiff's injury.

The Plaintiff in this matter began to feel ill after a rowing marathon. She was diagnosed in hospital as suffering from hyponatremia which is an electrolyte disturbance associated with low sodium levels and is a condition which can affect athletes who consume too much fluid during endurance events.

The Plaintiff recovered physically but developed ongoing post-traumatic stress disorder and depression which she alleged arose from a delay in the hospital in diagnosing her condition and consequent treatment with an intravenous drip which temporarily worsened her condition.

The Plaintiff lost her case.

The Court found that whilst the hospital may have been negligent in commencing the drip solution at the time that it did, there was no causal link between this act and the development of the Plaintiff's condition which was found to have arisen out of the hyponatremia itself and the requirement for hospitalisation.

The Judge observed that where a Plaintiff suffers a psychiatric injury, not a physical injury, as a result of treatment during hospitalisation the causal link between negligence and psychiatric injury may be harder to satisfy.

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