Medical Negligence

\*\*\*REMEMBER THAT THE CLA REPLACES THE COMMON LAW

1. INTRODUCTION
   1. Here [patient] has suffered [state loss/damage] as a result of [doctor]’s failure to take reasonable care in diagnosis, treatment and provision of information (*Rogers v Whittaker*) and as a result [patient] may sue in contract or negligence.

***Rogers v Whitaker***

* + *Woman had been almost completely blind after a childhood injury*
  + *Referred to a surgeon some 40 years later who said that he could improve the appearance of the eye*
  + *Did not warn that the operation may result in loss of sight to her good eye*
  + *This materialised and she was left completely blind*

1. ACTIONS IN CONTRACT
   1. [Patient] must be able to establish:
      1. A contract existed between the parties;
         1. The doctor/patient relationship is a contractual one, that is the elements offer (to provide health care), acceptance and consideration (payment) can generally be satisfied (*Breen v Williams*).
         2. It was implied into the contract [doctor] would take reasonable care
         3. Where there is a contract, the doctor usually undertakes to advise and treat the patient with reasonable skill and care (*Breen v Williams*).
   2. [Doctor] has breached that implied condition by failing to take reasonable care
      1. SEE NEGLIGENCE PROVISIONS
   3. [Patient] has suffered loss/injury as a result of that breach
      1. SEE NEGLIGENCE PROVISIONS
      2. [Patient] does not need to establish causation in order to be awarded nominal damages (*Chappel v Hart*)
      3. Damages will also not be reduced for contributory negligence, which may happen in an action for negligence (*Astley v Austrust*).
2. ACTIONS IN NEGLIGENCE
   1. [Patient] must be able to establish:
      1. [Doctor] owed [patient] a duty of care
      2. That duty of care has been breached
      3. [Patient] has suffered an injury or financial loss (ongoing medical expenses, loss of wages)
      4. The injury/loss was caused by [doctor]’s breach
      5. The injury/loss was foreseeable as a result of [doctor]’s breach.
   2. Duty of Care
      1. The following relationships are recognised categories of negligence
         1. Doctor and patient – Rogers
         2. Nurse – Langly
            1. ***Langly***

*Failure by nurses to count the amount of swabs going in and out of a patient – hospital was then found vicariously liable*

* + - 1. Hospital – *Barnett*
      2. Ambulance service – *Neal*
      3. Alternative health practitioner *– Shakoor*
         1. ***Shakoor***

*Patient was killed after taking a prescribed Chinese herbal remedy*

*Caused a rare reaction*

*HELD: duty is owed and the standard is that of a professional whom is able to prescribe medicine – medicine must not be actually or potentially harmful*

* + - 1. Receptionist – *Heise*
         1. ***Heise***

*Wife of a patient called to make an appt*

*Man died before appt*

*Held: Whilst a duty is owed there was no breach here as it was not booked in as urgent and there was no suggestion that the receptionist needed to prioritise*

* + - 1. Sexual partner of a patient – *BT; PD*
         1. ***BT v Oei***

*Pl husband went to dr before marrying pl and doctor recommended he be tested for HIC*

*He was positive but continued to have sex anyway and infected partner*

*Partner tried to sue Dr for failing to disclose*

***HELD:*** *Dr did owe a duty to disclose and diagnose – was not direct to partner but should encourage sharing of such information between partners*

* + - * 1. ***PD v Hafvey and Chen***

*Similar facts to above*

*Wife sued for failing to tell her of her husband’s positive results*

*Held that damages were owed for failing to advise husband to tell her or at the very least, advising to go and get counselling*

* + - 1. Unborn child of patient *( X v Pal)*
         1. Only for injury – NOT for wrongful life
         2. See notes under *Cattanach v Melchior, Harriton and Stephens* and s49A and s49B of the CLA
  1. **NO Duty**
     1. To attend in an emergency
        1. Contrast with *Lowns v Woods*
           1. ***Lowns v Woods***

*Pl suffered a epileptic fit and suffered serious brain damaged*

*Sister was sent to get a doctor to attend but the Dr refused*

*Dr later denied he had been approached and said that if e was he would have attended*

***HELD*** *although there was no pre-exisiting relationship between the parties the doctor owed the pl aduty of care that he breached by failing to attend*

*was liable for compensation*

*was upheld on appeal*

*NOTE: that this decision was made on NSW legislation provisions re professional misconduct that do not exist in QLD*

* 1. Breach of Duty

It is necessary to firstly determine what standard of care is owed, which is then followed by a consideration of whether that standard has been breached.

* + 1. What is the standard of care?
       1. Doctors have a duty to exercise reasonable skill and care in providing advice, diagnosis and treatment. The standard of care required under this duty is that of a normally skillful and careful medical practitioner (*Rogers v Whittaker*).
       2. Set using an objective test (Blyth)
       3. Some subjective factors can be considered
          1. Specialists have a higher standard than doctors
          2. Inexperience does not matter

There was the suggestion in Wilsher v Essex Area Health Authority that it would be lowered based on role not the person performing it

* + - 1. Knowledge is a factor
         1. SOC is bench marked at the time the knowledge is released

Swan; Roe; s22CLA

E.g. could not sue for the contraction of aids from a blood transfusion in the 80’s before screening was readily and widely available.

***Blyth***

* *Application of the Bolam test*
* *Duty to answer questions asked by the patient*
* *Patient was given an injection of a contraceptive following her pregnancy*
* *Had bad side effects*
* *Said she wouldn’t have taken the drugs if she knew this would be the outcome*
* *HELD (overturning the original decision): The practitioner was not negligent*
* *Note that cases such as Sidaway have distinctly moved away from this decision/approach*
  + 1. Has this duty/standard been breached?

There are essentially two provisions which give rise to breach

1. Section 21 – advice
2. Section 22 – diagnosis and treatment
   * + 1. Note that section 22 is also a form of ‘modification’ of the Bolam principle
          1. BOLAM

Acting out of necessity where it is not possible to communicate with the person by acting in accordance with a responsible and competent body of professional opinion

**ADVICE s21 CLA (Failure to warn**

* + - 1. *Failure to provide advice?*
         1. Section 21 CLA

A doctor is not in breach of duty to warn patient of risks unless the doctor fails to give:

Information that a **reasonable person** in the patient’s position would require to enable the person to make a reasonably informed decision (objective test, Proactive duty – reasonable person)

Information that the doctor knows **the patient wants** to be given before making the decision. (subjective test, Reactive duty – particular patient)

* + - 1. Has the doctor neglected to provide information?
         1. On the facts [doctor] has failed to provide [state information] to [patient]. Under s21 [doctor] was under a duty to warn [patient] of this material under (pick test – normal info vs particular info re circumstances).
         2. Is the information material?

Under the common law [patient] must prove the information not disclosed was material information or a material risk (Rogers v Whittaker)

Material risk is one where:

A reasonable person would attach significance to it

The medical practitioner is or should be aware that the particular patient would be likely to attach significance to it

Five factors to consider when determining a material risk

Nature of the matter to be disclosed

Do not assume patient knows common risks

A slight risk of serious harm might satisfy the test, while a greater risk of a small harm might not (*Rosenberg v Percival)*

A patient may be more likely to attach significance to a risk if the procedure is elective rather than life saving. (*Rosenberg v Percival)*

Nature of proposed procedure

Complex interventions (major surgery) require more information

Common risks in minor procedures do not need to be mentioned as an ordinary person is unlikely to be affected by them (*see Bustos v Hair Transplant*)

Elective surgery not clinically necessary (i.e. cosmetic surgery, sterilisation, IVF) require more information as an ordinary person would consider all risks, even if uncommon (*Shaw v Langely; Tekanawa v Millican*)

Patients desire for information

Patient need not ask about specific risk, it is enough the patient makes their concern known (see *Johnson v Biggs*)

The temperament and health of the patient

Information should take account of the patients circumstances, personality, expectations, fears, beliefs, values and cultural background (*NHRMC guidelines*)

The general surrounding circumstances

May have a duty to mention alternative treatments (see *Rosenburg* per Kirby J)

Fees and costs may be important

*Rosenberg v Percival*

*Dr P was a nurse with a PhD and consulted R (oral surgeon) about a worsening condition in her mouth*

*R recommended a surgical procedure but did not tell her of the risks arising from this surgery (pain in face)*

*After surgery, she could not speak loudly, eat hard food and suffered muscle spasms*

*Had to undergo psychiatric treatment and earning capacity was reduced*

*Such an outcome was rare*

*HELD: patient was unsuccessful, could not prove causation*

*Relevant factors to materiality*

*patients 20 years of experience as a nurse*

*patients knowledge surgery carries risks*

*patient’s worsening condition required treatment*

*patient had consulted with several specialist to get best results*

*appropriateness of the treatment in such cases*

*the small risk of harm*

*patient’s willingness to have a second operation to alleviate the pain of the first one*

* + - 1. Patient must prove failed to take reasonable care by not providing material information
         1. Q to be determined by court
         2. Patient must prove the doctor was at fault
         3. Court applies an objective standard the same for all doctors
         4. **(*Bolam Prinicple)***Section 22 CLA is also relevant as there will be no breach if the doctor acted in a way that was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice.
         5. Opinion need not be universal
         6. If it is ‘irrational’ court will reject it
         7. Expert evidence is generally presented
      2. May not be a breach if the doctor can show that he/she withheld information for therapeutic privilege
         1. Where the Dr’s duty to act in the best interests of the patient may require an evasive or less than fully candid answer even to a direct request *(F v R)*

***Battersby v Tottman*** (Therapeutic Privilege)

* *Eye Doctor didn’t tell a suicidal patient that a drug that she was using to control her mental illness may affect her eyesight*
* ***HELD:*** *This decision is justified*
* *If the patient had known of the risk it might have caused hysterical blindness*
* *Her mental illness precluded her from making a calm and rational decision*

**Expressions of regret**

* S68 – s 72 (CLA)
* Can make an expression of regret without it being admissible
* Can be oral or written
* Does not amount to an expression of liability on the part of the individual or someone else (s71 CLA)

**DIAGNOSE AND TREAT s22 CLA** (Bolam Principle)

A doctor may be negligent in his or her diagnosis through unreasonable delay, incorrectly assessing a patient or incorrect surgery (*O’Shea v Sullivan)*.

* 1. Again s22 CLA is also relevant, i.e. there will be no breach if the doctor acted in a way that was widely accepted by peer professional opinion by a significant number of respected practitioners in the field as competent professional practice.
  2. Opinion need not be universal
  3. If it is ‘irrational’ court will reject it
  4. Expert evidence is generally presented
     1. Again, this reiterates the Bolam principle immensely

**O’Shea’s Case**

* Woman successfully sued her general partitioner and pathologist who failed to diagnose her cervical cancer
* She died six weeks after the hearing
* Was awarded full damages
  + This decision has been criticised because it is not certain that the doctors actions could have prevented the eventual outcome

1. Damage

**The damage must be recognised at law:**

* **Physical injury and/or consequential loss** which are clearly recognized form/s of damage.
* **Death** as such it is open for the deceased’s estate to sue for financial loss as a result of death: *PIP Act*
* **Loss of opportunity** whilst recognised in some cases; in medical cases court has opted to assess damages by physical injury not loss of opportunity: *Chappel v Hart*. However this is not certain: *Chappel v Hart* (Dawson J); *Gavalas v Singh* (Calloway J) and particularly facilitating statements in *Rufo v Hosking*.
* **Loss of right to sue** may be recognised (even where prospects of action were uncertain): *Nikolaou v Papsavas*
* **Loss associated with legality** not recognised: *S v Superclinics* (loss of opportunity to abortion).
* **General anxiety and vexation**: *Coates v States Government Insurance Office* (Distinction between nervous shock and grief)
* **Cost of raising child:** s49A, 49B *CLA* – no award of damages for loss arising from cost of raising child.
  1. Patient must suffer injury/loss
     1. The onus is on [patient] who must be able to establish they have suffered an injury or loss to be successful in a claim for negligence (s12 CLA).
  2. **Patient must establish causation**
     1. The onus is also on [patient] to establish the damage they have suffered was causally related to [doctor]’s negligence (s11(1)(a) CLA)on balance of probabilities (s12 CLA); i.e. that
        1. The breach of duty was a necessary condition of the occurrence of the harm (factual causation)
        2. it is appropriate for the scope of the liability of the person in breach to extend to the harm so caused (scope of liability)
  3. **Factual causation s11 CLA**
     1. But for test *(March v Stramare) (s11(1)(a))* 
        1. Whether plaintiff’s damage would have occurred “but for” defendant's acts or omissions
     2. Material contribution (*McGee v National Coal Board)*
        1. Did the breach *cause or materially contribute* to the damage as a matter of *common sense and experience*
     3. The court also may have regard to what the person who suffered harm would have done if the person who was in breach of the duty had not been so in breach; however this is a subjective consideration and plaintiff cannot make statements about what they would have done (s11(3) CLA).

**Causation in fact:**

* P must be able to show that D’s act or omission cause the damage
* See Barnett v Chelsea
  + No Causal link b/w failure and eventual outcome as would have died anyway
* **COF at CL** 
  + March v Stramere
    - Common sense and experience test
    - Did acknowledge the operation of the “but for” test in some circumstances

**Causation at Law**

* Recommendation 29 of IPP
  + Necessary condition (factual causation)
  + Also considers scop – normative considerations
* Under the CLA
  + Restricted to necessary condition
  + Diff to CL approach as normative issues are only relevant at the second state of the enquiry
    - Ruddock v Taylor
  1. **Scope of Liability s11 CLA**
     1. Whether damage was reasonably foreseeable, whether it was a risk that would occur to the mind of a reasonable person in the defendant’s position and would not be brushed aside as far fetched or unlikely to occur
     2. Egg-shell skull principle: doctor must take patient as found even if they have a pre-existing condition which caused damage suffered was more severe than would have been the case (*Shorey v PT; Wieland v Cyril Carpets*)
     3. Under s11 (4) must consider loss allocation
  2. **Onus of proof** – **Section 12 CLA**
     1. Plaintiff will always bear on the balance of probabilities any factor relating to causation

**If damage relates to:**

Remember that the BREACH must cause the DAMAGE

* + 1. Failure to provide advice
       1. [Patient] must also be able to establish had they known of the relevant risk they would not have had the treatment or would have taken such steps to reduce the risk (*Rosenberg v Percival; Chappel v Hart*).
       2. Subjective test: s11(3), but note inadmissibility of plaintiff’s statements
       3. **Things you need to show**
          1. That they would have refused the treatment
          2. That the treatment would have caused the loss
          3. It has to be linked to the breach
          4. The breach must be the thing that has caused the harm
          5. If something else goes wrong –i.e. the anaesthetic goes wrong then that is not the breach – as it wasn’t a failure to advise
    2. Diagnosis and Treatment
    3. If the breach of duty relates to diagnosis or treatment, it is necessary to show that the negligent act or omission caused the plaintiff to suffer some damage (injury/potentially death).
  1. The damage needs to be recognised at law: e.g *Cattanch v Melchoir*
     1. E.g. where medical treatment would have saved their life, but not where the damage would have been suffered anyway

***Cattanch v Melchior***

* *Where parents were able to recover costs of child rearing for a healthy but unplanned child*
* *Reasons for allowing included* 
  + *Being entitled to compensation for all aspects of harm that are not too remote*
  + *Will not affect the child as it will understand that the claim was not because it was unwanted but for economic reasons*
  + *Birth of a healthy child is not always a blessing*

***Barnett v Chelsea & Kensington Hosp –*** *Would have suffered and died anyway*

* + *Three men drinking and all started to throw up*
  + *Nurse and casualty officer tell them to go home and call the doctor*
  + *Later in the day one of them died*
  + *There was arsenic poising in their tea*
  + *A duty of care was owed by casualty officer*
  + *But even if doctor had come in, the man would have died anyway as there was arsenic poisoning in his tea*
  + *So the doctor’s negligence didn’t cause the death*
  1. **Has there been an *intervening act?***
     1. Where there is an intervening act that breaks the chain of causation, the health care professional/hospital is no longer liable. However where further negligent medical treatment is given it will only be regarded as breaking the chain of causation where it is grossly negligent (*Mahony v Kruschich*)

1. Defences
   1. Patient has not suffered injury or loss
   2. Voluntary assumption of risk
   3. Emergency
   4. Necessity
   5. Therapeutic privilege
      1. s 16 *Law Reform Act*: good Samaritan
         1. applies to a doctor who was
            1. 16(a) [at/near] the scene of an [incident/other occurrence constituting an emergency/whilst transported]; and
            2. 16(b) rendering [medical care/aid/assistance] to an injured person; and
            3. 16(c) treatment is provided in good faith without gross negligence; and
            4. 16(d) without fee or reward or expectation of it.
   6. ss 26-7 *Civil Liability Act*: public safety
      1. ambulances etc won’t be liable where acting reasonably in public safety
   7. Doctor told patient about the risk in question
      1. Court will need to determine what was said as a Q of Fact
      2. E.g. if there is a consent form, prima facie evidence of knowledge of risk
         1. Not conclusive proof the patient was informed of the risks
   8. The risk was not material
      1. I.e. the risk was not material so it was justifiable not to mention it in the circumstances
      2. A risk may not be material where
         1. It is slight (i.e. bruising) or remote
         2. The patient is so ill no reasonable patient in that position would be likely to attach significance to it
         3. Patient does not want to discuss or have knowledge of the risks
         4. If there is no time for discussion
2. **Contributory negligence**
   1. Remember that this is only a partial defense (s10 LRA)
   2. Plaintiff’s failure to take reasonable care for their own safety where their own conduct contributed to their injury
   3. Plaintiff’s damages may be reduced
   4. Involves issues of causation and apportions fault based on respective culpability
   5. See sections 15 and 16 of the Law reform Act

**15 Definitions for pt 5**

* In this part—
* ***injured person*** includes a person suffering or apparently
* suffering from an illness.
* ***medical practitioner*** includes a person registered under a law
* of another State that provides for the same matter as the
* *Medical Practitioners Registration Act 2001* or a provision of
* that Act.
* ***nurse*** means a person registered as a nurse under the *Nursing*
* *Act 1992* or a corresponding law of another State or a
* Territory.

**16 Protection of medical practitioners and nurses and other**

**prescribed persons**

* Liability at law shall not attach to a medical practitioner, nurse
* or other person prescribed under a regulation in respect of an
* act done or omitted in the course of rendering medical care,
* aid or assistance to an injured person in circumstances of
* emergency—
  + - * 1. at or near the scene of the incident or other occurrence
* constituting the emergency;
  + - * 1. while the injured person is being transported from the
* scene of the incident or other occurrence constituting
* the emergency to a hospital or other place at which
* adequate medical care is available;
* if—
  + - * 1. the act is done or omitted in good faith and without
* gross negligence; and
  + - * 1. the services are performed without fee or reward or
* expectation of fee or reward.

**Doctor must prove**

* + 1. Plaintiff failed to exercise reasonable care for their own safety
       1. Q of fact judged in light of all the circumstances (*Caterson v Commissioner for railways)*
       2. Objective test to determine standard (*Joselyn v Berryman)*
       3. S23CLA applies and the standard required of the person who suffered harm is that of a reasonable person in the position of that person
       4. Therefore, contributory negligence is to be assessed against the same objective standard applied in establishing breach by the defendant.
    2. Once it is established the plaintiff failed to act reasonably it is necessary to prove that the damage suffered by plaintiff was caused by that failure
       1. Q of fact that requires the application of common sense (*Fitzgerald v Penn)*
       2. Evidence must show plaintiff’s failure to take reasonable care contributed to their loss in that the loss could have been avoided or reduced (*Wynbergen v Hoyts)*
    3. Damage was a reasonably foreseeable consequence of plaintiff's fault/negligence
       1. Type of injury suffered must have been reasonably foreseeable in the circumstances (*Joselyn v Berryman)*
    4. Apportionment of damages
       1. Not a complete defense, damages are apportioned between defendant and plaintiff on basis of relative fault and responsibility for the damage suffered, *(s10(1) Law Reform Act; March v Stramare*)
       2. court may determine there is 100% reduction in damages for plaintiff (defeating plaintiff's claim) if plaintiff’s actions contributed more to injury than defendant’s (*s24 CLA)*

***Locher v Turner***

* + 1. *Locher had cancer of colon*
    2. *Alleged doctor failed to do accurate test which would have led to earlier detection*
    3. *HELD: Damages were reduced by 20% where patient failed to adequately tell the doctor the nature and extent of her symptoms and did not return promptly as advised by the doctor.*

1. Statutory limitations/Procedures
   1. Time limits: 3 years (s11 LAAA)
   2. *Personal Injury Proceedings Act* –
      1. e.g. s20A-20J – procedural requirements for notification of claims in relation to injuries to children arising out of medical treatment
   3. *Civil Liability Act*
      1. e.g. ss 49A, 49B – no award of damages for loss arising out of costs of raising a child

**Harriton v Stephens**

* Child born with defects due to mother contracting rubella in her pregnancy
* Child attempted to sue doctor for negligence in failing to tell mother claiming that if mother had known she would have terminated and they would not have been born
* HELD: you cannot claim for wrongful life
  + See tab in text book
  + Arguments included that you cannot claim damages for ‘existence’ because it cannot be compared to non-existence as no one knows what that is like

**New Case Example from the lecture:**

***G & M Armellin [2009] ACTCA 6***

* *A LESBIAN couple who said having two IVF babies instead of one damaged their relationship have won an appeal against their doctor and been awarded $317,000 in compensation.*
* *In the first case of its kind in Australia, the Melbourne parents of the twin girls sued Canberra obstetrician Sydney Robert Armellin for implanting two embryos instead of the requested one.*
* *The couple, whose combined income is more than $100,000, sought $398,000 from Dr Armellin to cover the costs of raising one of the girls, including fees for a private Steiner school.*
* *In July last year, judge Annabelle Bennett rejected the couple's claim and ordered them to pay Dr Armellin's legal costs. The doctor had not breached his duty of care to the twins' birth mother and was therefore not negligent, Justice Bennett said.*
* *The court had heard that as she waited in the operating theatre, only moments before the procedure, the birth mother told Dr Armellin she wanted one embryo implanted. This was in conflict with an earlier written instruction to the clinic to transfer two embryos.*
* *The ACT Court of Appeal yesterday overturned that decision, ABC TV reported last night.*
* *The three judges of the appeal court awarded the couple, who can't be named for legal reasons, $317,000 in damages and ordered Dr Armellin to pay their legal costs.*