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"Update On Medical Negligence With Particular Reference To The Recent High Court Decision In *Tabet v. Gett*"

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In this update on medical negligence law I want to deal with three different timeframes at which a liability for a subsequent adverse outcome to a patient needs to be considered. These are failure to warn during the consultation process, failure to follow up following consultation and thirdly, the important issue of causation, namely what does the law recognise as compensable damage.

The third matter squarely raises for consideration the effect of the decision of the High Court of Australia in ***Tabet v. Gett*** [2010] HCA 12. Let me deal with the failure to warn issue first.

The leading case in this area prior to the statutory reforms of the law of tort in 2002 was ***Rogers v. Whittaker*** (1992) 175 CLR 479.

It is fair to say that at the time it was decided it sent a shudder through the medical profession and put a glint in the eye of plaintiffs' lawyers.

Mrs Whittaker had suffered an injury to her right eye when she was a child. When she was 47 years of age she was referred to Dr Rogers to see whether or not the vision in her right eye could be improved by the removal of scar tissue. Dr Rogers advised her that the operation would not only improve the appearance of her eye but would probably restore significant sight to it. On that basis she agreed to undergo the surgery.

There was no question that Dr Rogers had conducted the operation with the required skill and care.

Unfortunately the surgery did not improve the vision in her right eye but more importantly it led to the development of an inflammation in the left eye as an element of sympathetic ophthalmia causing loss of sight in the left eye with the result that she was almost totally blind.

The probability of this occurring in this type of surgery was once in approximately every 14,000 such procedures but it did not always lead to loss of vision. In this case it did and Mrs Whittaker sued Dr Rogers and succeeded upon the basis that he should have warned her of this risk and her evidence was accepted that had he done so she would not have consented to undergo the operation.

Prior to ***Rogers v. Whittaker*** the tendency of the law was to approach medical negligence cases on the basis that "*doctor knows best*".

A somewhat more technical way of expressing that legal proposition is to use the words of Lord Scarman in the House of Lords decision in ***Sidaway v. Governors of Bethlem Royal Hospital*** where he relevantly stated:

> *"A doctor is not negligent if he acts in accordance with the practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care; but the standard of care is a matter of medical judgment."*

That approach was not followed in ***Rogers v. Whittaker***. In that case the High Court said of the standard expected of medical practitioners:

> *"….is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade….*
>
> *While evidence of acceptable medical practice is a useful guide for the courts. It is for the courts to adjudicate on what is the appropriate standard of care after giving weight to 'the paramount consideration is that a person is entitled to make his own decisions about his life'."*

One can see from the approach of the High Court in ***Rogers v. Whittaker*** that there was a change in analysis from "*doctor knows best*" to "*judges know best*". The policy underlying the change was the right of persons to make decisions in relation to their

own life and that right could only be exercised if the decision was based upon informed choices including, obviously enough, the risks of an adverse outcome.

As medical practitioners present today who were in practice during the years following ***Rogers v. Whittaker*** will no doubt recall the effect of the decision was a significant increase in medical insurance premiums and an increase in what is sometimes referred to as "*defensive medicine*". Both costs were inevitably borne directly by medical practitioners but also indirectly by the community in additional professional time and additional tests being requested or ordered without specific request to deal with what may have been no more than remote possibilities.

The result when the Commonwealth government and all State governments embarked upon the process of tort reform several years later was to introduce a statutory formula, similar, but far from identical to the English test of "*a responsible body of medical opinion*".

I do not propose to discuss the implications of all of those statutory reforms because many of them are of a nature which will apply to all claims in tort and not just medical negligence claims but rather concentrate upon those provisions which have the most direct impact upon what was perceived to be the radical decision in ***Rogers v. Whittaker***.

The English position is often referred to by lawyers as the Bolam principle which takes its name from the earlier English decision of ***Bolam v. Friern Hospital Management Committee*** [1957] 2 All ER 118.

When the various states and territories reintroduced a variation of the Bolam principle this was not done uniformly although there are considerable similarities between the legislation in New South Wales, Victoria, Queensland, South Australia and Tasmania.

I will use the New South Wales formula because it is the one with which I am most familiar. The New South Wales *Civil Liability Act 2002* contains the following sections:

> *"Division 6*
>
> *Professional Negligence*
>
> *5O Standard of Care for Professionals.*
>
> *1. A person practising 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 that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice."*

This looks very much like the Bolam test but the legislation has some peculiar twists.

Subsection (2) of the same section states:

> *"However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational."*

I do not know what "*irrational*" in this context could mean. Nor am I aware of any cases which have considered its meaning in that provision. One would hope that medical practitioners other than those under supervision because of some impairment to their ability to practise would not engage in providing services to patients which were "*irrational*". No doubt some lawyer in some case will take the point that peer professional opinion in a particular area was "*irrational*" and there will be some judicial determination of what this word means in this context.

The Victorians, in their relevant legislation being the *Wrongs Act* of 2003 did not use the word "*irrational*" in the equivalent provision but the word "*unreasonable*", a word which has provided a useful standard by which to measure behaviour in many areas of the law.

The provisions go further than the test of widely accepted by peer professional opinion as competent professional practice in that subsection (3) states:

> *"The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section."*

And subsection (4) states:

> *"Peer professional opinion does not have to be universally accepted to be considered widely accepted."*

In other words, provided the opinion is not "*irrational*" if it is widely accepted as competent professional practice this will operate as a defence to a claim in negligence.

The irony in the statutory reforms is that although ***Rogers v. Whittaker*** was one of the main catalysts for the reform, the legislation would not protect Dr Rogers if it were being applied in the circumstances of that case. This is because s.5P of the *Civil Liability Act* provides:

> *"This Division does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in respect of the risk of death or injury to a person associated with the provision by a professional of a proper professional service."*

The result is that the "*judges know best*" test has been overruled but at the same time the legislation has preserved the right of patients to be fully informed of the risks associated with any procedures. The legislative amendments thus provide a protection to medical

practitioners in the carrying out of procedures provided they are done in a manner which accords with "*peer professional opinion as competent professional practice*" but at the earlier stage of any analysis of a medical negligence case, namely the provision of information, warnings and in particular properly advising patients of the risks associated with any procedure the "*right to know*" policy identified in ***Rogers v. Whittaker*** remains.

There is, however, one other important reform of the law, criticised by judges in the "*failure to warn cases*" that is worth mentioning. That is the prohibition upon any plaintiff giving evidence about what they would have done had they been given the relevant warning or information.

This prohibition finds expression in s.5D of the New South Wales *Civil Liability Act* which has a subsection 3 which is in the following terms:

> *"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 the light of all relevant circumstances, subject to paragraph (b) and*
>
> *(b) any statement made by the person after suffering the 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."*

To a trial lawyer this is a peculiar provision. Of course, all plaintiffs are going to say, after having had an adverse outcome, that if given the appropriate warning or the necessary information they would not have gone ahead with the procedure. This is colloquially known as "*hindsight bias*". Such a belief may be honestly held or based on being "*wise after the event*". It would, however, be unusual to find a plaintiff who would say that they would nevertheless have undergone the procedure even if they had

been provided with the relevant warning or information. If they would have consented anyway they would not have a "*failure to warn*" case. Thus it is hard to understand why the statute includes the exception that any such statement is admissible if it is "*against his or her interest*".

Judges have criticised the provision and in my opinion rightly so. It is simply a question of fact as to whether or not in all the circumstances a patient would have undergone the procedure if provided with the warning or information which for the purposes of this discussion it must be assumed was negligently not provided.

Judges are acutely aware of "*hindsight bias*" and there are many matters that would be taken into account as an ordinary process of fact finding before a judge would come to the conclusion that even if a plaintiff said that he or she would not have undergone the procedure.

Many of these are set out in the judgment of the High Court of Australia in ***Rosenberg v. Percival*** (2001) 205 CLR 434 and included in the list are:

(i) The seriousness of the plaintiff's need for the relevant medical intervention.

(ii) Whether the condition that required the medical intervention was one that was worsening.

(iii) Whether the procedure was one that was commonly and frequently carried out without adverse consequence.

(iv) Whether there were realistically any alternatives to the treatment offered for the condition from which the plaintiff was suffering.

(v) Matters personal to the circumstances of the particular patient including their social and domestic circumstances, their religious beliefs, their level of education and knowledge of medicine, whether they usually followed medical advice and whether they had previously undergone medical procedures without requesting information.

(vi) Whether the plaintiff was concerned about risks and asked about them.

(vii) Whether the plaintiff was willing to undergo a general anaesthetic.

(viii) The magnitude of the risk. In other words, the more remote the possibility of the adverse consequence occurring the less likely as a matter of ordinary fact finding that a judge would find that it would have made any difference to the patient's decision to go ahead with the procedure.

One can see from an examination of these criteria that it is arguably offensive to judges to suggest as the statute does that they are not allowed to be told what might be relevant or important information because they will give at the answer undue weight and overlook all relevant evidence to the contrary, let alone be ignorant of the effects of "*hindsight bias*" on plaintiffs giving that evidence.

Interestingly enough, contrary to what the draftsmen of that provision may have had in mind courts were well aware of the effects of hindsight bias. See, for example, ***Johnson v. Biggs*** [2000[NSWCA 338, ***Rosenberg v. Percival*** (2001) 205 CLR 434, ***Bridge v. Pelly*** [2001] NSWCA 31.

Before I discuss ***Tabet v. Gett*** which is now authority for the proposition that "*loss of a chance*" of a better outcome does not give rise to an entitlement to damages, I want to say something about the "*follow up*" cases.

When one looks at the principles underlying the right to be told relevant information one would have thought that there was a corresponding principle that patients who had in fact been given advice or relevant information had a responsibility in respect of their own health and if they failed to act responsibly to follow up the results of tests or act on referrals to a specialist, the doctor would not have any liability for failing to follow up.

That has not been the case. The law in this area has consistently applied a principle that the nature of the doctor's responsibility to the patient is ongoing in relation to a duty to follow up subject to certain exceptions.

Cases where that principle has been applied have included where the hospital has lost the admission form and the doctor did not follow up on the recommended procedure (***Tai v. Hazistavrou*** [1999] NSWCA 306). Another case is where a patient had been "*sent home*" to "*think about*" whether to undergo an operation but had not thereafter given a decision one way or another (***Samios v. Repatriation Commission*** [1960] WAR 219). Another is where a general practitioner ordered tests to be carried out, did not receive results from the tests, as he should have done but failed to follow up on obtaining the results (***Thomsen v. Davison*** (1975) QR 93). Another is where a patient had failed to undergo recommended cholesterol tests for the purposes of investigating his cardiac status, the doctor had done nothing to follow up the patient's failure to undertake the necessary tests and he subsequently had a heart attack (***Young v. Central Australian Aboriginal Congress Inc*** [2008] NTSC 47). Finally, where a patient had been referred to a specialist, it was inconvenient for the patient to attend that particular specialist because of the amount of travelling required, and she asked for a referral to another specialist and was told to wait to see the first one but due to the distance involved did not go, the doctor did not follow up and she developed cervical cancer and he was held liable (***Kalokerinos v. Burnett***, unreported Court of Appeal 30.01.1996).

The principle behind all of these cases appears to be that once the doctor/patient relationship is established the failure of the doctor to follow up even if the patient does nothing amounts to a failure to complete the treatment process. In cases where investigations are involved if the doctor does not follow up on the investigations then

negligence is established upon the principle that the doctor has a duty to pursue investigations until a diagnosis is made for the particular complaint and the failure to follow up on the investigations is a breach of that obligation.

In medical negligence, as in all other areas of the law, the situation is rarely "black and white" when it comes to findings of liability in cases involving a failure to follow up. The exceptions to the general principle as set out above include the seriousness of the condition, the duration of time over which the doctor and patient relationship has existed, the extent to which the doctor has emphasised the importance to the patient of the need to undergo the further tests or investigations, the ease with which the follow up procedures could have been accomplished and whether or not, in the case of general practitioners, the responsibility for the management of the patient has been passed to a specialist. The other important word of warning in relation to the follow up cases is that there are many cases where the real cause of the failure to follow up was the lack of a systematic system of administration within the medical practice to monitor whether or not the necessary follow up had occurred. In ***Kite v. Malycha*** (1998) 71 SASR the court expressed the view that it was "*…unreasonable for a professional medical specialist to base his whole follow up system, which can mean the difference between death or cure, on the patient taking the next step…when the simplest of systems could have provided an easy way to follow up.*"

That brings me to the next case that I wanted to discuss which represents the other side of the coin. What is the position when the doctor should have advised follow up and does not do so and this materially increases the risk of an adverse outcome to the patient.

This is the case of ***Sydney South West Area Service v. Stamoulis*** [2009] NSWCA 153**.**

The original proceedings were brought by Mrs Christine O'Gorman against "BreastScreen NSW Sydney South West" and she succeeded at trial but the Court of Appeal found a number of errors in the approach taken by the trial judge to evidentiary matters and remitted the matter for re-trial. The detail of the legal errors is not relevant for present purposes. What is relevant is that on the second trial Mrs O'Gorman's estate, she having since died from the undetected breast cancer, succeeded in proving negligence against the radiologists who examined her mammograms on behalf of the organisation known as "BreastScreen".

Mrs O'Gorman had been undergoing mammograms at "BreastScreen" every two years and in between 2004 and 2006. What was interpreted as a cyst in her left breast grew from approximately 2cms to 2.5cms in diameter between 2004 and 2006 but this did not trigger any follow-up by way of ultrasound or biopsy.

Within a year or so the "cyst" had metastasised to her lungs and brain causing her death. The trial judge found and the Court of Appeal agreed with the finding that, on the statistical evidence the delay in diagnosis materially caused the metastasisation of the cancerous tumour because it increased the risk of the cancer metastasising by 10%.

This then brings me to the discussion of the decision of the High Court in ***Tabet v. Gett*** [2010] HCA 12.

The plaintiff in that case was a six year old girl and the doctor was a well regarded specialist paediatrician. Ms Tabet had an undiagnosed tumour in her brain called a medulloblastoma.

She first came under the care of Dr Gett on 11 January 1991 with a history of a resolving chickenpox rash and a history of headache and vomiting since at least 18 December 1990.

Dr Gett made a diagnosis that she had either chickenpox, encephalitis or meningitis and organised for her to be admitted to hospital on that day. On 13 January 1991 observations were made of her that she was irritable and drowsy and complaining of headache. Her pupils were noted by nursing staff to be unequal and the right pupil was not reactive. Dr Gett was contacted and he ordered a lumbar puncture. This is a procedure to obtain cerebro spinal fluid to test for the presence of bacteria. If present, it would confirm the diagnosis of meningitis which in layman's terms is a bacterial inflammation of the surfaces around the brain.

Dr Gett did not order a CT scan and the trial judge found that in the circumstances it was negligent of him not to have done so.

On the next day, namely 14 January 1991, Ms Tabet was observed to be staring and unresponsive with her pupils deviating to the left. Dr Ouvrier, a neurologist, was called and he ordered a CT scan which revealed the medulloblastoma.

A neurosurgeon operated two days later to remove the tumour.

The outcome for the plaintiff was that she sustained severe brain damage.

Her case was that had the CT scan been ordered earlier the severity of the brain damage may have been reduced. Her case was that the negligence of Dr Gett in not ordering the CT scan when her symptoms and signs warranted that course deprived her of the chance of a better outcome for which she was entitled to be compensated in damages.

She succeeded in recovering damages at trial but lost in the Court of Appeal and in the High Court.

The approach of the trial judge was to assess her as having a 40% chance of a better outcome if the CT scan had been ordered on 13 January and the tumour detected at that time.

The finding of the trial judge was that the delay in detecting the tumour was responsible for 25% of the damage thereafter sustained and since there was a 40% chance of a better outcome and the total quantification of the claim was approximately $6 million, she was awarded $600,000 being 40% of 25% of $6,000,000.00.

Both the Court of Appeal in New South Wales and the High Court held that this analysis was wrong.

Although there are differences in the reasoning between the appellate judges involved what was fundamental to the approach taken was that the common law of negligence deals in the proof of probabilities not possibilities.

In other words since there was no finding that it was more probable than not that the plaintiff's condition was worsened by the delay in diagnosis she was not entitled to any compensation for the possibility that it may have been.

Put simply, the law does not recognise "*loss of a chance*" as being compensable.

How then, does one distinguish ***Stamoulis*** from ***Tabet v. Gett*** where the plaintiff recovered 100% of her damages?

The distinction is to be found in the fact that in ***Tabet v. Gett*** the plaintiff already had the pre-existing tumour and it was going to produce severe brain damage in any event.

Proof that the delay in diagnosis could have made any difference to the outcome did not reach the balance of probabilities and therefore the negligence could not be held to be the cause of the subsequent damage.

In ***Stamoulis***, Mrs O'Gorman died because the tumour that she had in her breast metastasised to her lungs and to her brain. The statistical probability of that occurring by the time the cancer was in fact detected was 62%. The tumours that developed in her lungs and brain were not found to be something that was there in any event (unlike the tumour in the brain of Ms Tabet) but rather developed because of a material increase in the risk of those tumours developing by reason of the misreading of the mammograms and the failure to order follow up investigations as a result. In other words the missed diagnosis made it more probable than not that the cancer would metastasise to her lungs and brain than if it had been detected one year earlier.

Some quotations from the High Court judgment in ***Tabet v.*** Gett make clear that to approach caudation in medical negligence cases otherwise than on the basis that proof of damage on the balance of probability is required would involve a significant change in the law. For example, Gummow ACJ stated:

> *"In personal injury cases the law of negligence as understood in the common law of Australia does not entertain an action for recovery when the damage, for which compensation is awarded consequent upon breach of duty, is characterised as the loss of a chance of a better outcome of the character found by the trial judge in this case."*

Hayne and Bell J in a joint judgment said:

> *"To accept that the appellant's loss of a chance of a better medical outcome was a form of actionable damage would shift the balance hitherto struck in the law of negligence between the competing interests of claimants and defendants. That step should not be taken. The respondent should not be held liable where what is said*

> *to have been lost was the possibility (as distinct from probability) that the brain damage suffered by the appellant would have been less severe than it was."*

Justice Kiefel said:

> *"The requirement of causation is not overcome by redefining the mere possibility, that such damage as did occur might not eventuate, as a chance and then saying it is lost when the damage actually occurs. Such a claim could only succeed if the standard of proof were lowered which would require a fundamental change to the law of negligence."*

Justice Crennan said:

> *"Policy considerations which tell against altering the present requirement of proof of causation in cases of medical negligence include the prospect of thereby encouraging defensive medicine, the impact of that on the Medicare system and the private medical insurance schemes and the impact of any change to the basis of liability on professional liability insurance of medical practitioners. From the present vantage point, the alteration to the common law urged by the appellant is radical, and not incremental, and is therefore the kind of change to the common law which is, generally speaking, the business of Parliament."*

For reasons already identified in this paper in relation to the discussion of tort reform it seems fairly clear that Parliament is unlikely to legislate to permit such an expansion of the law of negligence and that the law in Australia will remain as set out in ***Tabet v. Gett***, namely that a plaintiff must positively prove on the balance of probability that the damage sustained was caused by the negligence of the relevant medical practitioner and is not entitled to damage even when negligence is established solely on the basis that he or she was deprived thereby of the opportunity of a better outcome.

The points to be taken away from this presentation are:

(i) Patients must be fully advised of the risks. To avoid any dispute the advice should be given orally and confirmed in a signed acknowledgement.

(ii) Patient care is an ongoing obligation which requires accurate recording and active steps to monitor that recommendations or tests have been followed up. In these days of computerised record keeping failure to do so will be held to be negligent.

(iii) Plaintiffs must prove that any negligence that is established actually caused the adverse outcome. Mere proof that the negligence deprived the plaintiff of the chance of a better outcome will be insufficient.