

MEDICAL NEGLIGENCE

DUTY OF CARE OF MEDICAL PRACTITIONER

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Introduction

- 1 I have been asked to speak about:
 - 1.1 The test of the duty of care owed by a medical practitioner according to *Rogers v Whitaker* (1992) 175 CLR 479 at 483;
 - 1.2 Applying the test;
 - 1.3 Establishing a breach of the duty of care.

Duty of care

- 2 The duty owed by a medical practitioner to a patient is a duty to exercise reasonable care: *Rogers v Whitaker* (1992) 175 CLR 479 at 483 and 489; *Strempel v Wood* [2005] WASCA 163 [28] per McLure JA. Where the patient consults with the doctor directly and agrees to pay a fee a corresponding duty is owed in contract: *Astley v Austrust Ltd* (1991) 197 CLR 1. Where a hospital provides the doctor's service the hospital owes the patient a duty of care: *Cassidy v Ministry of Health* [1951] 2 KB 343; *Samios v Repatriation Commission* [1960] WAR 219.

- 3 At a general level what is more significant about *Rogers v Whitaker* is what it says about the content of the standard of care that is required to be exercised to discharge the duty of care. That is, what is “reasonable care”?

Standard of care

- 4 At the level of the specifics of the case *Rogers v Whitaker* is about liability of a doctor for not warning a patient about a risk that may lead to a potentially serious adverse outcome from a medical procedure.
- 5 The decision was given in a context of two prior English cases that largely left determination of that standard to the medical profession. The important shift by the High Court in *Rogers v Whitaker* was to place the principles that determine liability for medical negligence firmly within the constellation of rules that govern liability in tort generally. Essentially liability was to be a question for the court, rather than the medical profession.
- 6 The first English case that provided the background context for *Rogers v Whitaker* was *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582.
- 7 In *Bolam* the plaintiff, a mental patient, underwent electric shock therapy which caused severe injuries consisting of dislocation of both hip joints with fractures of the pelvis on each side. The plaintiff had not been warned of the risk of fracture which was very small - namely, the order of 1 in 10,000. Relaxant drugs, which would have excluded the risk of fracture, were not used.
- 8 There were two bodies of opinion in the psychiatric profession about whether relaxant drugs should be used. There were different views on whether the patient should be warned about the risk of fracture. The jury was directed that a doctor was not negligent if he acted in accordance with a practice accepted as proper by a responsible body of

medical men skilled in that particular art, merely because there was a body of such opinion that took a contrary view.

- 9 The next case, almost 20 years later, was *Sidaway v Governors of Bethlehem Royal Hospital* [1985] AC 871. A surgeon employed by the hospital performed an operation on the plaintiff's spinal column to relieve pain. He did not warn her that there was a very small risk (less than 1%; that is, 1 in 100) of damage to her spinal cord that might lead to mild to very severe injury. The operation was performed skilfully but the spinal cord was injured and the plaintiff became severely disabled.
- 10 The House of Lords adopted the test from the trial Judge's summing up to the jury in *Bolam* (which they called the "*Bolam* test") and held that the test of liability in respect of a doctor's duty to warn a patient of risks inherent in treatment recommended was the same as the test applicable to diagnosis and treatment. The doctor was required to act in accordance with a practice accepted at the time as proper by a responsible body of medical opinion.
- 11 In *Sidaway* Lord Scarman at 881 described the *Bolam* test as:

"The *Bolam* principle may be formulated as a rule 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. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment".
- 12 The *Bolam* test was reviewed and rejected by the High Court in *Rogers v Whitaker* (1992) 175 CLR 479. The plaintiff was almost totally blind in her right eye. She underwent surgery to that eye and developed inflammation in her left eye that led to total loss of vision in that eye. She would not have undergone her surgery had she been advised of the risk to the left eye. The risk of that complication was of the order of about 1 in 14,000 procedures.
- 13 The High Court held that a medical practitioner has a duty to warn a patient of a material risk inherent in proposed treatment. The risk was material if:

- 13.1 In the circumstances of a particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or
- 13.2 If the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.
- 14 The court rejected the *Bolam* test and held that the standard of care required of a medical practitioner is not determined solely or even primarily by reference to the practise followed or supported by a responsible body of opinion of the relevant profession. However responsible professional opinion will have an influential, often a decisive role to play, in determining whether a medical practitioner has carried out a particular form of treatment in accordance with the appropriate standard of care.
- 15 In *Rosenberg v Percival* (2001) 205 CLR 434 Gleeson CJ said that in many cases professional practice and opinion will be the primary, and in some cases it may be the only, basis upon which a court may reasonably act [7]: *Kerr v Minister for Health* [2009] WASCA 32 [26].

Applying the test

- 16 *Rogers v Whitaker* has been applied by the Court of Appeal in Western Australia in a number of cases. The earliest example after *Rogers v Whitaker* was the decision of the Full Court in *Tai v Saxon* (FCt of WA, unreported, 8 February 1996, Lib 9760113). An obstetrician and gynaecologist was held to have been negligent when he failed to warn his patient that the procedure he was to perform involved a risk that her rectum might be perforated and a fistula (in that case the connection between the rectum and the vaginal wall) might occur. The plaintiff was an anxious person who had suffered depression and lacked self-confidence.

- 17 Evidence was given by two senior obstetricians and gynaecologists. One said that the relevant risk was “very slight” and that it might be “one in a thousand, something like that - may even be less than that”. It was nevertheless a well recognised risk. The other expert regarded the risk as being “very remote - very rare”. The court considered that the second limb of the test in *Rogers v Whitaker* applied - that the risk was material (although slight) because the doctor in that case was, or should reasonably have been aware, that this patient, if warned of the risk, would be likely to attach significance to it.
- 18 In *Percival v Rosenberg* (the appeal judgment at [1999] WASCA 31 was overturned by the High Court on causation grounds (2001) 205 CLR 434) the plaintiff underwent surgery to her jaw to correct malocclusion. Afterwards she experienced severe temporomandibular joint (TMJ) complications. She claimed that the oral surgeon was negligent in failing to warn her beforehand of risks inherent in the surgery. The trial judge found that the appellant did not fail to warn the respondent of any material risk. None of the other specialists who had seen the plaintiff and examined the x-rays before the operation had come to a conclusion that there was, or could be, any TMJ problem. He also held that even if the respondent had been warned of the possibility of TMJ complications, she would have proceeded with the surgery in any event.
- 19 In *Kerr v Minister for Health* [2009] WASCA 32 the claim was against a hospital for the conduct of its anaesthetist. Pethidine was prescribed for maxillary sinus surgery. The plaintiff suffered a seizure and subsequently injuries to her sternum and spine when cardiopulmonary massage was instituted by nurses. She claimed that she should have been warned of the risk of seizure. The Court of Appeal held that the risk of risk was material because a reasonable person in the appellant's position, if warned of the risk, would be likely to attach significance to it: [34]. The anaesthetist breached his duty.

However the appeal by the plaintiff was dismissed because treatment with pethidine did not cause her seizure. The incident in this case occurred on 7 August 2003.

20 From 1 December 2004 the standard of care required of a doctor has been governed by sub-ss. 5PB(1) and (2) of the *Civil Liability Act 2002* (WA) as follows:

- “(1) An act or omission of a health professional is not a negligent act or omission if it is in accordance with a practice that, at the time of the act or omission, is widely accepted by the health professional’s peers as competent professional practice.
- (2) *Subsection (1) does not apply to an act or omission of a health professional in relation to informing a person of a risk of injury or death* associated with —
 - (a) the treatment proposed for a patient or a foetus being carried by a pregnant patient; or
 - (b) a procedure proposed to be conducted for the purpose of diagnosing a condition of a patient or a foetus being carried by a pregnant patient.” (my emphasis)

21 The law as enunciated in *Rogers v Whitaker* remains the law notwithstanding the apparent return to the *Bolam* test in other areas by virtue of the statutory change effect by the *Civil Liability Act 2002*.

Establishing breach of duty

22 In my view these questions should be asked:

22.1 What injury occurred?

22.2 Did the doctor fail to warn the patient that occurrence of the injury was a risk associated with the procedure to be undertaken?

22.3 Was the risk of occurrence of the injury “material” in that:

22.3.1 A reasonable person in the patient’s position, if warned of the risk, would have likely attached significance to it? or

22.3.2 The medical practitioner knew or should reasonably have known that the patient, if warned of the risk, would have likely attached significance to it?

22.4 What was the cause of the injury?

22.5 Would the injury have occurred if a warning had been given?

23 These questions will be answered by a combination of lay and expert evidence.

Evidence of consultations, significance of risk and effect of warning

24 Statements should be taken from the patient and any friend or family member who attended a consultation. The statements must address what was said at consultations and issues relevant to showing what the patient, or a reasonable patient, would have done if warned of the risk. The evidence must address the doctor's knowledge of matters that would suggest that the patient, or a reasonable patient, would attach significance to the risk.

25 It must be remembered that evidence from the patient as to what he or she would have done is not admissible: s.5C(3)(b) of the *Civil Liability Act 2002*. Without more it would rarely be helpful evidence: see *Rosenberg v Percival* (2001) 205 CLR 434 at 486. The patient could however give evidence of treatment preferences based on rational grounds. For example, the evidence that the patient was an anxious person who had suffered depression and lacked self-confidence (as was the case in *Tai v Saxon*) would be relevant to the issue of what the patient would have done in response to a warning.

26 In *Hall v Petros* [2004] WADC 87 a uro-gynaecologist failed to warn his patient of the risk of chronic infection associated with surgery to treat incontinence. The surgery resulted in the patient experiencing chronic infection associated with scarring from the procedure. The trial judge held that the plaintiff would not have undertaken the surgery if warned of the risks. The plaintiff gave evidence at trial (not revealed in the judgment) that she had a preference for natural remedies. That evidence was capable of supporting the conclusion that she would not have undertaken a surgical procedure if warned that it carried a risk of chronic infection.

Experts

- 27 Expert evidence will be required as to the cause of the injury and the degree of risk and nature of complications associated with the procedure. A number of questions need to be answered. What was the physical cause of the injury? Would the injury have occurred if a warning had been given and different treatment had been undertaken? What if no treatment had been undertaken? Would it have occurred irrespective of what was done?
- 28 Expert evidence on risks of complications should be founded on information from objective and verifiable sources such as results of (preferably controlled) studies of patients, or documented widespread clinical experience, found in journals and texts. In the absence of supporting reference to objective material or standards it is never sufficient, or admissible, for an expert to say what he or she would have done or what should have been done.

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