Doctors, Patients and the Courts - Are We On a Dangerous Slippery-Slope?
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Major Issues

The 1992 High Court decision in Rogers v. Whitaker heralded a new era of legal scrutiny of the behaviour of doctors in Australia. That scrutiny has been accompanied by a heightened awareness amongst both the medical profession and the wider community that doctors are at risk of being sued successfully by their patients.

This paper examines the legal rules in Australia that determine whether a doctor's behaviour amounts to professional negligence. These rules have developed at common law. Under these rules, a doctor whose behaviour is substandard is held liable for the cost of the harm resulting from that behaviour. Although the limits on Commonwealth powers contained in the Australian Constitution have caused issues relating to the delivery of health and medical services to be seen largely as matters to be addressed at State and Territory level, the way in which the legal system compensates people injured by substandard medical care has important implications for all Australians.

The operation of the legal system in this area therefore is attracting greater attention at Federal level. It is one of the issues being explored by the Review of Professional Indemnity Arrangements for Health Care Professionals ('the Tito Review') within the Commonwealth Department of Human Services and Health. The Final Report of the Tito Review is currently being prepared and is expected to be released later this year. Consideration of any proposals for reform arising out of the Tito Review should be accompanied by as complete an understanding as possible of the legal rules that determine when a doctor will be liable in negligence.

The rules at common law governing the standard of care that doctors must meet when treating patients were outlined by the High Court in 1992 in Rogers v. Whitaker. Doctors must exercise 'reasonable' care and skill when providing professional services to patients. They must display this care and skill in respect of all aspects of their professional behaviour. There are differences between the legal rules determining the standard of care that doctors must meet when diagnosing and treating a patient's condition, and the legal rules determining the standard of care they must meet when providing a patient with information and advice about medical treatment. In all cases, however, the standard of care ultimately is set by the courts rather than the medical profession.

The statements of legal principle in Rogers v. Whitaker raised many important questions concerning the scope and exact content of doctors' legal duties to their patients. Some questions related to doctors' duties when providing information to patients. These questions remain largely unanswered, despite the application since 1992 by Australian courts of the
relevant *Rogers v. Whitaker* rules. Other questions related to doctors' duties when conducting diagnosis and treatment. More detailed answers to these questions have been provided in recent cases in which courts have applied *Rogers v. Whitaker* when scrutinising allegedly negligent diagnosis and treatment by doctors.

Four of these recent cases - *O'Shea v. Sullivan, Burnett v. Kalokerinos, Woods v. Lowns and Others* and *Maffei v. Russell and Another* - have been particularly important. All four were decided by Australian courts in the past year and received a great deal of media attention. Each involved allegations that a doctor had been negligent in diagnosing or treating a patient's medical condition. All four cases illustrate in application the *Rogers v. Whitaker* rules on this issue and extend and develop those rules. As a result, there now is more clarity concerning how a doctor must behave in order to avoid liability for negligent diagnosis or treatment.

Questions remain, however, concerning how doctors' newly-defined legal responsibilities will affect the way in which they practise medicine. There has been considerable speculation on this matter. This speculation often has been based on an incomplete and inaccurate understanding of the recent changes to the law governing the doctor-patient relationship. This misunderstanding has in turn led to a widespread misconception that the legal rules governing doctors' professional behaviour place them in an impossibly difficult situation, and that these rules are leading inevitably to a medical malpractice 'litigation crisis' of the kind seen in the United States.

A better understanding is needed of the relevant legal rules and of how they may be applied. Such an understanding will enable doctors, patients and lawyers to influence the development of these rules in an informed and constructive way. It will also assist politicians and policy makers at all levels of government in their assessment of any proposed changes to those rules.
Introduction

Medical negligence actions are in the news:

- Dying mother sues two doctors.¹
- Culprits' bid to shift Pap smear blame fails.²
- Medicine of fear: how the law is changing the treatment you get from your GP.³
- Breast cancer: sue fear 'spur to operations'.⁴
- Doctors throw out baby as costs soar.⁵
- Lawyers could drive the doctors out.⁶
- Litigation threat kills patients, says doctor.⁷

This selection of recent newspaper headlines reflects the increased attention that the media is paying to cases in which patients sue their doctors in negligence. It also indicates the nature of much of that attention.

In the past year, four Australian medical negligence cases have attracted an unusually high level of media scrutiny. In three of these cases - O'Shea v. Sullivan, Burnett v. Kalokerinos and Woods v. Lowns and Others - the courts held in favour of the patient bringing the action and ordered the doctors to pay substantial damages. In the fourth case, Maffei v. Russell and Another, the patient's action failed.

This paper examines these cases and discusses the extent to which they represent a change in the approach of Australian courts to assessing negligence claims brought by patients against their doctors. Particular attention is given to the claim that these cases represent a further development of an 'anti-doctor' trend in Australian law, which allegedly began with the decision of the High Court of Australia in the 1992 case of Rogers v. Whitaker. The paper examines the argument that the law has begun to 'turn against' doctors by holding them to unreasonably high standards that leave the legality of doctors' day-to-day medical practice uncertain.
The Point of Recent Departure - The Law as Stated in Rogers v. Whitaker

The Standard of Care: Reasonableness

To bring a successful negligence claim against a doctor, the person bringing the action - 'the plaintiff' - must establish the following:

1. The doctor owed the plaintiff a duty of care;
2. The doctor breached the duty of care, ie failed to meet the required standard of care;
3. The breach of duty caused the plaintiff to suffer injury; and
4. The injury is of a kind that is compensable at law.

It is the second of these elements, the standard of care owed by a doctor, that is of particular importance in connection with the claim that Australian law is beginning to treat doctors with undue severity. It is the legal rules in relation to the standard of care that must be met by a doctor which have recently been under greatest judicial scrutiny, and which therefore deserve examination. For that reason, the legal rules in relation to the other elements of a successful negligence action will not be explored in any depth in this paper.

The law does not demand perfection of doctors. Nor does it require them to guarantee the success of any medical treatment. The law instead requires doctors to exercise 'reasonable' care and skill in their provision of professional services. A failure to behave reasonably in the circumstances can expose a doctor to liability in negligence, provided the plaintiff can also establish that the damage suffered by the plaintiff was caused by that negligent behaviour.

The standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill. A doctor therefore is not required to possess the highest expert skill. It will be sufficient if the doctor exercises the ordinary skill of an ordinary competent person practising in that particular field of medicine. A general practitioner must exercise the ordinary skill of an ordinary competent general
practitioner, a neurosurgeon must exercise the ordinary skill of an ordinary competent
neurosurgeon, an obstetrician must exercise the ordinary skill of an ordinary competent
obstetrician, and so on.

The doctor must exercise reasonable care and skill in respect of all aspects of the
professional services provided by the doctor. Thus reasonable care and skill is
demanded in respect of diagnosis and treatment of the patient's condition. Reasonable care
and skill is also demanded in respect of the provision of information and advice to the
patient. The High Court of Australia has emphasised that there is 'a fundamental
difference between, on the one hand, diagnosis and treatment and, on the other hand, the
provision of advice or information to a patient'. The legal test of what constitutes
reasonable behaviour in respect of diagnosis and treatment therefore is different from the
legal test of what constitutes reasonable behaviour in respect of the provision of advice and
information. There are, however, important similarities in emphasis, both in theory and in
application, between the two tests. Although it is the former test - the test of what
constitutes reasonable behaviour in respect of diagnosis and treatment - that was applied
by the courts in Woods v. Lowns and Others, O'Shea v. Sullivan, Burnett v. Kalokerinos
and Maffei v. Russell and Another, both tests are considered below in some detail.

The Doctor's Duty I: Providing Advice and Information

Rogers v. Whitaker - a duty to disclose material risks

In the landmark case of Rogers v. Whitaker in 1992, the High Court of Australia outlined
the test for determining whether a doctor has fallen below the required standard of care in
respect of providing information about risks associated with medical treatment. Although
some lower Australian courts had given rulings on this issue, this was the first time the
High Court had addressed the question of the extent of the legal duty of doctors to provide
patients with information about treatment.

The plaintiff in that case was a woman aged in her 40s who had been blind in one eye
since childhood as the result of an accident. The defendant, an ophthalmic surgeon,
advised her that surgery on her blind eye would improve its appearance and probably
would restore significant sight to it. She agreed to the surgery, as a result of which she
developed sympathetic ophthalmia in her good eye and was rendered almost totally blind.
The doctor had not informed her of the risk of sympathetic ophthalmia (which occurs in approximately 1 in 14,000 operations of this kind), despite the fact that she had 'incessantly questioned' him about possible complications of the operation. The plaintiff claimed that the doctor's failure to inform her about this risk constituted negligence. The High Court upheld her claim on the basis that the doctor had not met his obligation to inform her of all 'material risks' associated with the operation. In their joint judgement, Mason CJ, Brennan, Dawson, Toohey and McHugh JJ stated that a risk is material if, in the circumstances of the particular case, either:

- a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it; or
- if the doctor is or should reasonably be aware that this particular patient, if warned of the risk, would be likely to attach significance to it.¹⁴

The standard of care required by the law, in respect of the provision of information about risks inherent in medical treatment, therefore is determined by the court with reference to the 'needs, concerns and circumstances of the patient.'¹⁵ It is not determined by reference to the standards or practices of the medical profession - the court has 'simply no occasion to consider the practice or practices of medical practitioners in determining what information should be supplied.'¹⁶ The reason given by the High Court for this conclusion was that 'no special medical skill' is involved in disclosing information to a patient.¹⁷

Evidence of medical practices will be relevant in this context only when assessing whether a doctor was justified in withholding information because the patient was 'unusually nervous, disturbed or volatile' and in 'particular danger' of being harmed as a result of being informed. In these limited situations a doctor will be protected by the 'doctrine of therapeutic privilege' and a failure to inform about material risks will not constitute negligence.¹⁸

A wider duty to inform the patient - how far does it extend?

The negligent failure to inform in Rogers v. Whitaker was a failure to tell the patient about a material risk associated with a procedure. In discussing that failure, the High Court inferred that a doctor's duty to inform a patient about material risks forms part of a wider, general duty to inform a patient.²⁰ The exact scope of that duty in Australia remains unclear. Arguably, however, a doctor has a legal obligation to provide a patient with all information to which 'the patient' - either a reasonable person in this particular patient's position, or this particular patient who has special needs and concerns of which the doctor is or should be aware - would attach significance in deciding whether or not to consent to a proposed medical procedure.²¹ This could include information about alternatives to the
proposed procedure (including non-treatment), information about any further procedures that might be necessary, information about how the patient's behaviour could affect the likelihood that the procedure will succeed, and relevant information about the medical condition for which treatment is proposed.22

Another question raised, but not answered, by the judgements in Rogers v. Whitaker is the extent to which the law places the onus upon the doctor to be alive to any special needs and concerns that the patient might have about treatment, rather than upon the patient to make the doctor aware of those special needs and concerns. For example, it is not clear when a doctor should 'reasonably be aware' that a patient has special needs and concerns. When might the law consider that a doctor is 'put on notice' by the particular characteristics of a patient - whether they arise from the patient's personal, social, economic, cultural or religious background - that the patient is likely to have special needs and concerns about treatment, about which the doctor should reasonably be aware? When might the law place a doctor under a legal obligation to question a patient,23 to discover whether the patient has special needs and concerns?

Further unanswered questions arise from the fact that in outlining (albeit imperfectly) a legal test that indicates what a doctor should tell a patient, the High Court was silent as to how the patient should be told. This was an unfortunate omission, given that the High Court indicated that its test was driven by the principle that doctors should provide information to meet the needs, concerns and circumstances of the patient. It is difficult to see how the needs, concerns and circumstances of the patient can be met unless information is provided in a way that is likely to be understood by the patient. This is recognised in the following statements from the National Health & Medical Research Council's General Guidelines for Medical Practitioners on Providing Information to Patients ('the NHMRC Guidelines'):24

... patients may have difficulty comprehending the information given by doctors. It is important that doctors use language which is simple and free of medical jargon, and that they try to ensure that the information is understood and retained ...

... information should be provided in a form and manner which help patients understand the problem and treatment options available, and which are appropriate to the patient's circumstances, personality, expectations, fears, beliefs, values and cultural background ...

The way the doctor gives information should help a patient understand the illness, management options, and the reasons for any intervention. It may sometimes be helpful to convey information in more than one session. The doctor should:

• communicate information and opinions in a form the patient should be able to understand;
doctors, patients and the courts

• allow the patient sufficient time to make a decision. the patient should be encouraged to reflect on opinions, ask more questions, consult with the family, a friend or adviser. the patient should be assisted in seeking other medical opinion where this is requested;
• repeat key information to help the patient understand and remember it;
• give written information or use diagrams, where appropriate, in addition to talking to the patient;
• pay careful attention to the patient's responses to help identify what has or has not been understood; and
• use a competent interpreter when the patient is not fluent in English. [preferably, the person acting as interpreter should be a trained medical interpreter and not a family member.]27

the NHMRC guidelines do not have the force of law, but do purport to 'reflect the doctor's existing common law responsibility always to take reasonable care. the guidelines may be consulted in disciplinary or civil proceeding in deciding whether the doctor has behaved reasonably in giving information, although ultimately it will be the role of the court to decide the reasonableness of a doctor's behaviour in a given case'.28

It therefore would have been helpful if the High Court had indicated whether, and to what extent, a doctor is under a legal obligation to do more than simply engage in 'information disclosure' to patients. At its worst, lack of attention to the way in which information is provided arguably 'leads to a perfunctory approach to consent in the clinical context and reinforces an unsatisfactory, simplistic and unilateral model of information transfer, of physicians talking 'at' rather than 'with' patients'.29 the relevant legal rules therefore should encourage attention to the substance as well as the form of a doctor's response to a patient's needs and desire for information:

... what is at issue is not so much legal liability or the adequacy and appropriateness of disclosure as the degree of understanding, the quality of the clinical interaction and the process by which decision-making is informed. It is clear that, in providing information, the doctor is not simply meeting legal requirements or institutional standards, or providing value-neutral data, but is participating in a shared dialogue that should be responsive to the needs, wishes, capacities and expressed concerns of that particular patient. Where the process of consent embodies shared decision-making, effective communication and optimal interactional skills, it not only satisfies the legal requirements regarding subjective factors but also optimises informed decision-making. The importance of this cannot be overstated as the clinical relationship between patients and health care professionals involves a continuous flow of decisions focused on the present and future health of the patient. Any set of requirements that makes disclosure the key item ... incorporates dubious assumptions about medical authority, about physician responsibility, and about legal theories of liability."
A similar sentiment is expressed in the NHMRC Guidelines:

An open exchange between doctors and patients is crucial. Each brings to the consultation different information, options and understanding which are important for making decisions and achieving the patient's well-being. Allowing opportunity for discussion may be as important for patients as giving and receiving information. 31

Filling in the gaps left by the High Court?

*Rogers v. Whitaker* was welcomed by plaintiffs' lawyers and advocates of the rights of health care consumers, who praised both the particular result in the case and the High Court's more general statements of legal principle relating to the doctor-patient relationship. The case was seen by many commentators as rejecting an outdated model of the doctor-patient relationship, based on paternalism and deference to professional discretion, in favour of a more appropriate legal model which acknowledges that patients are entitled to make decisions about their medical treatment based on adequate information.

*Rogers v. Whitaker* was less happily received by many doctors and their representatives. It was variously claimed that: both the reasoning and the result in this case were unduly biased in favour of the patient; that the case would encourage large numbers of patients to sue their doctors and lead to a United States-style litigation crisis; and that the case showed that the legal system was making it more and more difficult for doctors to continue to practise medicine, by interfering to an unacceptable extent with the way in which they exercised their professional judgement.

Some of this criticism of *Rogers v. Whitaker* undoubtedly stemmed from a perception that, by making it clear that the adequacy of advice provided by a doctor would be judged by a court-imposed standard rather than by one determined by fellow doctors, the High Court had engaged in an unacceptable attack on the medical profession. At least some of the criticism of *Rogers v. Whitaker*, however, may be attributed more to what the High Court did not say in this case, rather than to what it did say. As discussed above, *Rogers v. Whitaker* raised but did not fully answer a number of questions about the extent of a doctor's duty to inform her or his patients. The answers to these questions are important because they will determine the respective legal rights and responsibilities of each party to the doctor-patient relationship. The clearer and more certain the answers to these questions, the more confident both doctors and patients can be that their conduct when interacting will be considered to be 'reasonable' by a court of law.
There have been a number of cases since Rogers v. Whitaker in which Australian courts have applied the legal rules articulated by the High Court concerning a doctor's duty to inform patients. These cases should dispel at least some of the fears expressed by the medical profession in relation to the practical implications of the High Court's ruling. The cases since Rogers v. Whitaker illustrate that the more patient-oriented test advanced by the High Court has not resulted in a legal regime which is skewed in favour of plaintiffs who assert negligence in relation to provision of information about medical treatment. Although some of the patients who have sued their doctors on this basis have been successful, others have not. Moreover, Australian courts are yet to be inundated with patients alleging their doctors have been negligent in this way.

In all these cases following Rogers v. Whitaker the allegations of negligence have been limited to the claim that the defendant doctor failed to advise the patient of material risks associated with a medical procedure. The courts have not been required to address broader questions about the scope and content of a doctor's duty to inform patients that were raised by, but not addressed in, the judgements in Rogers v. Whitaker. Nor have the judges in these cases chosen to make comments that would indicate how they might answer these broader questions in the future. Considerable uncertainty therefore remains as to the detail of the duty to inform patients. Arguably, however, it is only a matter of time before cases come before the Australian courts which require judges to provide that detail.

Although the legal rules relating to a doctor's obligation to inform and advise a patient have not developed significantly since the 1992 decision in Rogers v. Whitaker, there has been more judicial activity recently in relation to the other aspects of a doctor's duty of care. The legal test of what constitutes reasonable behaviour in relation to diagnosis and treatment has been re-examined in a number of recent cases, the most important of which are Woods v. Lowns and Others, O’Shea v. Sullivan, Burnett v. Kalokerinos and Maffei v. Russell and Another. These cases have been the subject of a great deal of media attention but little detailed and considered analysis. It therefore is important to attempt the latter. This cannot be done without first returning to Rogers v. Whitaker and examining the comments made by the High Court concerning a doctor's duty to exercise reasonable care in respect of diagnosis and treatment.

The Doctor’s Duty II: Diagnosis and Treatment

The plaintiff in Rogers v. Whitaker did not allege that the defendant doctor had been negligent in diagnosing her condition, nor in the manner in which he performed the
operation. The High Court nonetheless discussed the test for determining whether a doctor has fallen below the required standard of care in relation to diagnosis and treatment.

The High Court stated that a court's inquiry into whether a doctor has met the standard of care in relation to diagnosis and treatment is 'a question of a different order' from whether the standard of care has been met in respect of providing information. Accordingly, 'responsible professional opinion will have an influential, often a decisive role to play' when a court is examining whether a doctor exercised reasonable care and skill in diagnosis and treatment.

The High Court was not prepared to accept, however, that the standard of care in relation to diagnosis and treatment should be determined solely by the practices of the medical profession. The High Court confirmed that in Australia the law in this area is not governed by what is known as 'the Bolam test', an approach to the standard of care which was developed in the English case of Bolam v. Friern Hospital Management Committee and which has been applied almost invariably by English courts. Under the Bolam test, what constitutes the exercise of reasonable care by a doctor is not determined by the courts, but instead is governed by the practice of the medical profession:

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 judgement.

To avoid liability in negligence under the Bolam test, a doctor need not conform to the practice accepted as proper by all, or even most, doctors practising in the area. The doctor need only conform to the practice accepted as proper by 'a responsible body' of doctors, even if their opinion is a minority view within the profession. A doctor will only be negligent under the Bolam test if the doctor acts in a way that 'no doctor of ordinary skill' would behave.

Serious doubt had existed in Australia concerning the applicability of the Bolam principle, in respect of diagnosis and treatment, for some time prior to Rogers v. Whitaker. The High Court dispelled that doubt in Rogers v. Whitaker. The majority judges - Mason CJ, Brennan, Dawson, Toohey and McHugh JJ - stated the following:

In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person professing to have that special skill. But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion within the relevant profession or trade. Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the Bolam principle has not always been applied.
In her minority judgement in *Rogers v. Whitaker*, Gaudron J was even more emphatic in rejecting the *Bolam* principle in relation to diagnosis and treatment:

... even in the area of diagnosis and treatment there is, in my view, no legal basis for limiting liability in terms of the rule known as 'the *Bolam* test' which is to the effect that a doctor is not guilty of negligence if he or she acts in accordance with a practice accepted as proper by a responsible body of doctors skilled in the relevant field of practice. That is not to deny that, having regard to the onus of proof, 'the *Bolam* test' may be a convenient statement of the approach dictated by the state of the evidence in some cases. As such, it may have some utility as a rule-of-thumb in some jury cases, but it can serve no other useful function. 42

In summary, the High Court in *Rogers v. Whitaker* made it clear that Australian law has regard to what the medical profession considers to be responsible behaviour when deciding what constitutes an exercise of reasonable care and skill in relation to diagnosis or treatment. Thus a court will consider, and give great weight to, medical expert evidence concerning the relevant practices of the medical profession in assessing whether a doctor fell below the standard of care demanded by the law. Since *Rogers v. Whitaker*, however, it has been equally clear that an Australian court is not bound to conclude that a doctor exercised reasonable care and skill simply because the expert evidence reveals that the doctor did what a responsible body of doctors would have done in the circumstances.

The High Court thereby confirmed that the law will treat medical professionals no differently from members of other professional groups when assessing whether they have breached their duty of care to a plaintiff. Like solicitors, bankers and other professionals, doctors in Australia cannot escape liability in negligence simply because their conduct has been in conformity with an accepted body of practice within their profession. 45
Major Developments Since Rogers v. Whitaker - the Woods, O'Shea, Burnett and Maffei Cases

As noted above, the main question in each of Woods v. Lowns and Others, O'Shea v. Sullivan, Burnett v. Kalokerinos and Maffei v. Russell and Another was whether the doctor in question had fallen below the standard of care which the law requires a doctor to meet in relation to diagnosis and treatment. In Woods v. Lowns and Others, the professional behaviour that was scrutinised was the way in which the defendant doctors responded to the patient's correctly diagnosed condition. In the other three cases, the allegedly negligent behaviour was the doctor's failure to diagnose cancer at a stage when it could have been treated successfully. These four cases illustrate the application of the basic legal rules set out in Rogers v. Whitaker concerning negligent diagnosis and treatment. They also develop some of these rules, in ways that provide more guidance than Rogers v. Whitaker as to the respective legal obligations of doctors and patients, but also raise further unanswered questions about those obligations.

Woods v. Lowns and Others ('the Woods case')

The facts and the court's findings

Patrick Woods, a ten year old, suffered an epileptic fit in 1987 while on holiday with his family on the NSW Central Coast. As a result he incurred brain damage and spastic quadriplegia. He sued a number of doctors in negligence in relation to their management of his medical condition. One of these doctors, Dr Procopis, was the paediatric neurologist who for a number of years prior to the fit had been responsible for managing his epilepsy. The plaintiff alleged that Dr Procopis had been negligent in failing to prescribe rectal diazepam (Valium), and in failing to instruct the child's parents in its administration, for use in emergencies where an epileptic fit occurred where professional medical care was not readily accessible. This was the situation which in fact arose. Badgery-Parker J of the Supreme Court of New South Wales agreed that Dr Procopis had been negligent in this aspect of his management of the patient's condition, even though the expert medical evidence indicated that the course adopted by the doctor accorded with accepted medical practice in Australia at the time:

... the decision by Dr Procopis not to prescribe the use of rectal diazepam accorded with what was regarded by his peers in this country as the proper standard for Patrick Woods ... of good medical practice at that time. That, of course, does not conclude the matter in the
defendant's favour for it is the law, not the medical profession, which determines the standard of care which is required.  

Badgery-Parker J concluded that Dr Procopis had breached the duty of care he owed Patrick Woods, because:

... it was incumbent upon him in the exercise of reasonable care and skill as a specialist paediatric neurologist to instruct the parents about the use of rectal diazepam and to equip them to administer it.  

Patrick Woods also succeeded in his negligence action against another doctor, Dr Peter Lowns. Dr Lowns was a general practitioner whose private rooms were located near the scene of Patrick Woods' fit. The court accepted evidence that Dr Lowns had been asked by Patrick Woods' sister to attend and treat her brother, but that the doctor refused to leave his surgery. No pre-existing doctor-patient relationship existed between Patrick Woods and Dr Lowns, so the success of the plaintiffs' claim depended upon the court finding that the doctor had owed the child a duty of care in these circumstances. The court found that Dr Lowns had owed a duty of care to Patrick Woods. This duty arose because the child was in urgent need of medical treatment. As Dr Lowns had been alerted to that need for emergency care, his failure or refusal to attend the child without reasonable cause amounted to a breach of his duty of care.

The court was satisfied that Patrick Woods would not have suffered the injuries that resulted from his epileptic fit had Dr Lowns and Dr Procopis not breached the duty of care they owed him. The court ordered the doctors to pay Patrick Woods total damages of $3,200,000.

Discussion

The central issue in Patrick Woods' action against Dr Lowns was not whether the doctor had breached the duty of care he owed a patient. It was rather whether he owed the child, who was not his patient, a duty of care at all. This limb of the Woods case therefore did not develop the legal rules in relation to the standard of care that a doctor must meet in order to fulfill the duty of care owed to a patient. Badgery-Parker J's finding against Dr Lowns nonetheless is significant and deserves some examination, because it was the first time a doctor in Australia has been held liable in negligence for failing to attend a person who was not the doctor's patient.

There is a general rule at common law that no person, not even a doctor, is under a legal obligation to rescue a stranger. In the Woods case, Badgery-Parker J stated that, notwithstanding this general rule, 'circumstances may exist in which a medical practitioner
comes under a duty of care, the content of which is a duty to treat a patient in need of emergency care. In concluding that such circumstances had existed in this case, the court was strongly influenced by the fact that Dr Lowns' behaviour would have constituted professional misconduct under paragraph 27(1)(h) of the *Medical Practitioners Act 1938 (NSW)* and could have formed the basis for disciplinary action under that legislation. The effect of this limb of the *Woods* case therefore is not to impose on doctors an entirely new obligation to provide medical treatment to any person who is not their patient. Its effect is rather to expand the effect of breaching an existing legal obligation. The case establishes that a doctor in New South Wales may be liable to pay civil damages for the injury caused by one specific kind of behaviour - failure without reasonable cause to assist in an emergency - which the legislature has already identified as substandard and deserving of legal sanction.

No other Australian State or Territory, however, has a statutory provision similar to paragraph 27(1)(h) of the *Medical Practitioners Act 1938 (NSW)*. Thus it is unclear from the *Woods* case whether doctors outside New South Wales would be liable in negligence for failing without reasonable cause to provide medical care to a non-patient in an emergency situation. Arguably they would, because Badgery-Parker J relied on more than the relevant statutory provision to conclude that there was a relationship of sufficient proximity between Dr Lowns and Patrick Woods for the doctor to owe the child a duty of care. He additionally relied on the following facts:

- Dr Lowns was aware that the child faced a major, life-threatening medical emergency requiring urgent attention
- Dr Lowns was competent and well equipped to treat the child
- Dr Lowns was only 300 metres from the site of the emergency
- Dr Lowns was approached at his place of practice
- Dr Lowns was ready to begin his day's work and was not occupied in any other professional activity which would have precluded him from treating the child
- what was asked of Dr Lowns involved no risk to him
- Dr Lowns was not disabled by any physical or mental condition from travelling to and treating the child (for example, he was not tired, ill or inebriated).

It is difficult to imagine any reasonable doctor failing to respond to a request for assistance in these circumstances. It does not seem unjust to impose civil liability on a doctor who fails to do so. Accordingly it would be unsurprising if Australian courts generally affirmed the existence of a duty of care in these extreme circumstances.
The second limb of the *Woods* case, the action against Dr Procopis, did focus on the question of whether the doctor had breached the duty of care he owed a patient. Badgery-Parker J's findings on this issue seem to involve a straightforward application of the statements in *Rogers v. Whitaker*, to the effect that Australian courts will not allow doctors to avoid liability for negligent treatment or diagnosis simply because their behaviour is supported by a responsible body of medical opinion. On one view, however, the judgement in the *Woods* case represents an extension of the principle underlying those statements. It can be argued that the statements in *Rogers v. Whitaker* criticising the Bolam test rested on a desire to avoid a situation where a doctor could escape liability simply by locating a minority body of medical opinion supporting the way that doctor had managed the patient's condition, even though the doctor's behaviour would have been criticised as inappropriate by a majority of the doctor's professional peers. This was not the situation, however, in the *Woods* case. In that case, Dr Procopis was far from being in a minority of his peers and far from having behaved in a medically unorthodox or controversial manner. On the contrary, he had behaved in a way that no other neurologist in Australia would have considered inappropriate - the evidence was that 'it had never become the practice of specialists in the field in Australia to recommend the use of rectal diazepam' in the situation that had faced this doctor.  

In finding Dr Procopis negligent, Badgery-Parker J rejected as unreasonable the approach of the medical profession to instructing parents of epileptic children in the emergency use of rectal diazepam. Thus it can also be argued that the result in the *Woods* case was entirely consistent with the principle underlying the earlier criticisms in *Rogers v. Whitaker* and *Bolam* test if, that underlying principle was simply that the courts will always reserve the right not to defer to medical professional opinion and practice when setting the legal standard of care. Support for this claim may be found in statements by Reynolds JA of the New South Wales Court of Appeal in the 1980 case of *Albrighton v. Prince Alfred Hospital*. In that case, Reynolds JA rejected the assertion that a doctor cannot be found to have been negligent if that doctor has provided medical treatment 'in accordance with the usual and customary practice and procedure then prevailing in...a particular 'medical community'. He further stated:

... 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.

This latter comment in particular foreshadows the result in the *Woods* case, where the fact that all the medical practitioners in Australia habitually failed to take an available precaution to avoid foreseeable risk of injury to their patients who were children with epilepsy (by failing to instruct their parents in the emergency use of rectal diazepam) was not enough to protect one of their number from being found negligent. Although the High Court in *Rogers v. Whitaker* did not specifically approve these statements in *Albrighton v.*
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Prince Alfred Hospital, neither did it criticise them. Nor did it attempt to draw any distinction between the situation where a doctor's allegedly negligent behaviour is 'merely' supported by a responsible minority body of medical opinion, and a situation where that behaviour is supported by the practice of the entire medical profession. An appeal against Badgery-Parker J's decision in the Woods case will be heard by the NSW Court of Appeal in December 1995. It remains to be seen whether an appeal court will draw this distinction, and use it to conclude that the Woods case represented an unacceptable departure from the position of the High Court in Rogers v. Whitaker.

Regardless of this issue, the finding against Dr Procopis in the Woods case is an illustration of what can happen when the courts and doctors have different views as to what is reasonable medical management in the circumstances. It is to be hoped and indeed expected that cases where such disparities arise will be rare, for each such case entails a conclusion by the court that the practice accepted as appropriate by the medical profession is of an insufficiently high standard. If the courts began to do this regularly, there could be a serious erosion of patients' confidence in the quality of medical care they receive from doctors. There could also be a serious erosion of doctors' confidence that adhering to the standards set by their professional peers will protect them from legal liability. To avoid these undesirable results, the courts should take care only to reject universally accepted medical practices where these are patently unreasonable, and the medical profession should also take care to examine its own practices more critically before the legal system undertakes that task on its behalf.

O'Shea v. Sullivan ('the O'Shea case')

The facts and the court's findings

In late 1987 Rhonda O'Shea, then aged 23, consulted her general practitioner, Dr Susan Sullivan, because of irregular intermenstrual bleeding which she experienced whilst taking the contraceptive pill. Dr Sullivan believed that the bleeding had hormonal causes and accordingly prescribed a higher dose of oral contraceptive. Dr Sullivan's notes of a further consultation in August 1988 recorded that the patient had experienced bleeding in the third week of the pill cycle and some bleeding after sexual intercourse. Dr Sullivan believed this bleeding too was due to hormonal causes and prescribed another contraceptive pill. She also asked Rhonda O'Shea to return when the bleeding ceased to have a Papanicolaou (Pap) smear. Dr Sullivan performed the smear in September 1988. At this time she also examined the patient and saw what she believed was a benign erosion on her cervix.
The Pap smear was examined by Macquarie Pathology Services who issued Dr Sullivan with a report indicating the presence of the mildest form of atypical cells - 'monilia with mild squamous atypia cells possibly due to inflammation'. This report was incorrect, as the smear in fact indicated the presence of very atypical cells - pre-cursor (CIN 3) cancer cells and possibly also micro-invasive cancer cells which demanded urgent investigation and treatment. Dr Sullivan considered the Pap smear results to be consistent with her initial diagnosis that the bleeding was caused by hormonal problems. She saw the patient again in late October 1988 and advised her to return for another Pap smear in three to four months' time. Rhonda O'Shea did not return to see Dr Sullivan, but instead consulted another general practitioner in December 1988 seeking a second medical opinion concerning her continuing post-coital bleeding. That general practitioner referred her to a gynaecologist who saw her in February 1989. It was discovered that Rhonda O'Shea had carcinoma of the cervix, and a radical hysterectomy and pelvic lymphadenectomy were performed in March 1989. Despite this, the cancer spread and she required further surgery, radiotherapy and chemotherapy. Rhonda O'Shea died of cancer in June 1994.

Before she died, she successfully brought a negligence action in the Supreme Court of New South Wales against Dr Sullivan and Macquarie Pathology Services.

Macquarie Pathology Services was found negligent on the basis that its error in interpreting the Pap smear slide would not have occurred if reasonable care had been taken in examining and reporting on the slide. The difference between what the slide indicated (very atypical cells) and what was reported (mild atypia) was so marked that the incorrect assessment could not be explained as an acceptable difference of interpretation. The error was unacceptable in terms of proper practice.

Dr Sullivan was found negligent on the basis that her management of Rhonda O'Shea's condition had involved the exercise of less than reasonable care by an ordinary general practitioner of ordinary competence. Her failure to exercise reasonable care was held by Smart J to comprise the following:

• failing to undertake a sufficiently thorough initial investigation of Rhonda O'Shea's condition, 'with insufficient attention being paid to the existing symptoms and their possible consequences'. Smart J emphasised the need for thorough and rigorous investigation where a patient has recurrent post-coital bleeding, because of the possibility of cancer. Where cancer is a possibility, this worst possible diagnosis must be excluded because 'unlike some other diseases and conditions, there is always the risk that there will be no second chance if it is missed through insufficiently rigorous initial investigations.'
• failing at any time to regard cancer in a woman aged 23-24 as a real possibility. Smart J stated that although cervical cancer in this age group is extremely uncommon, the serious nature of the disease means that all medical practitioners must 'take into account that young ladies do suffer from cancer. Five young ladies aged 10-24 per year in New South Wales is not insignificant'.

• failing at any time to warn Rhonda O'Shea of the possibility that her bleeding could mean she had cancer. Smart J stated that this had deprived the patient of the opportunity to pursue the matter quickly and effectively. Because of the consequences of cancer, patients should be alerted expressly to the possibility so that they can pursue the matter by having tests and ensuring that all steps are taken promptly.

• failing to refer Rhonda O'Shea to a gynaecologist in August 1988, after she had reported post-coital bleeding. Smart J stated that once symptoms of cancer exist the patient should be referred for proper assessment. Given the presence of post-coital bleeding, Dr Sullivan should not instead have waited for Pap smear results.

• failing to use the Pap smear result appropriately, as a screening test only rather than as a tool for reliable diagnosis. Smart J held that Dr Sullivan should not have been reassured by those results, should not have waited for a further Pap smear to be taken three months later, and should not have continued to fail to refer the patient to a gynaecologist. He emphasised that the Pap smear is not a test upon which too much reliance should be placed if the diagnosis of cancer is under consideration; if a Pap smear does not show cancer it should not be assumed that cancer is not present. This is because there is a significant risk (as high as 20%) that a Pap smear will yield a 'false negative' result, and mistakes can be made in interpreting smears.

• mistaking the malignancy that was probably present and visible on Rhonda O'Shea's cervix in September 1988 for a benign erosion, which was 'not pursued as it should have been'. This was described by Smart J as part of Dr Sullivan's overall failure to 'put the pieces of evidence she had together in a meaningful way'.

Smart J held that if Rhonda O'Shea's cancer had been detected and treatment commenced by October or November 1988 she would probably have been treated successfully, because there was no secondary spreading of the cancer before December 1988. This failure to provide Rhonda O'Shea with timely diagnosis and treatment was held to be equally attributable to the negligence of Dr Sullivan and to the negligence of Macquarie Pathology Services. They were each ordered to pay half the total damages award of $442 000. The defendants appealed against the amount of this award, but the appeal was rejected by the NSW Court of Appeal on 16 August 1994. Both defendants also appealed against the equal apportionment of damages by the primary judge. That appeal was rejected by the NSW Court of Appeal on 28 March 1995.
Discussion

The O'Shea case has been criticised on a number of grounds. First, it has been alleged that the court did not judge Dr Sullivan according to the standard of the reasonable general practitioner, but rather according to the standard of the reasonable specialist gynaecologist. This allegation stems from the heavy reliance placed by the court upon the evidence of two specialist gynaecologists in support of the conclusion that Dr Sullivan had been negligent in her management of Rhonda O'Shea's condition. Thus, it is claimed, Dr Sullivan's actions 'were not judged by her peers', but rather by members of a different branch of medicine with a different knowledge base. This criticism overlooks the fact that the court did receive evidence from another general practitioner as to the reasonableness of Dr Sullivan's actions, but that evidence did not assist Dr Sullivan's case. It also overlooks the fact that, as the Bolam test is not part of Australian law, an allegedly negligent doctor is not ultimately 'judged by her peers' but rather by the court. The criticism does, however, validly highlight the need for the court to take great care in its assessment and use of expert medical evidence, and to appreciate that differences exist between the practices and approaches of different branches of medicine.

Secondly, it has been claimed that the O'Shea case imposes on general practitioners a new and inflexible 'duty to refer' which will have bad consequences for both doctors and patients. The court in the O'Shea case embraced the following 'golden rule' advanced by one of the specialist gynaecologist witnesses: 'abnormal bleeding is due to cancer until proven otherwise'. To prove otherwise and discharge their duty to patients, general practitioners must refer patients with this symptom (or any other symptom which might possibly indicate cancer) to an appropriate specialist. Concern has been expressed that, to avoid potential liability, general practitioners increasingly will err on the side of caution and refer patients to specialists in circumstances where referral is clinically inappropriate and unnecessary. Critics suggest that this will place increased strain on scarce specialist services, expose patients to the risks and inconvenience associated with extra testing procedures, and increase the financial costs of health care to both patients and the community. The extent to which these developments will eventuate remains to be seen. It also remains to be seen whether the cost of such developments would be seen by the community as an acceptable price to pay for earlier detection of cancer in some patients.

Thirdly, there has been criticism of the court's finding that Dr Sullivan's negligence and resulting delay in diagnosis caused the harm suffered by Rhonda O'Shea. This criticism asserts that the court erred in concluding that Rhonda O'Shea's cancer would have been treated successfully had treatment commenced four months earlier, because that conclusion required the court to identify the date at which the secondary spreading of the cancer began and to predict the likelihood of successful treatment before that date. Both tasks arguably required the court to engage in an inappropriate degree of speculation, given the unpredictable way in which cancer progresses and the lack of evidence as to
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precisely how far Rhonda O'Shea's cancer had progressed at any time before it was detected. This criticism may be countered by noting that the law does not require these matters to be proved beyond any reasonable doubt, but only on the balance of probabilities. The court in the O'Shea case acknowledged that the nature of Rhonda O'Shea's disease meant that 'there could be no certainty' in its conclusion, but stated that on the expert evidence before the court 'the probabilities favour the view' that Dr Sullivan's negligence deprived the patient of a cure. It also should be noted that a great many medical negligence claims fail because, even though the damaged patient can show that the defendant doctor did not meet an acceptable standard of care, the patient cannot establish that the doctor's behaviour caused the harm suffered. Thus, even if the court in the O'Shea case could be criticised as having interpreted the evidence relating to causation in a manner overly generous to Rhonda O'Shea, there are no signs that this is indicative of a broader tendency by Australian courts to favour plaintiffs whose actions otherwise would fail due to inability to establish causation.

The fourth major criticism of the O'Shea case centres on the fact that the court found Dr Sullivan to be negligent largely on the basis of a version of certain events that was the subject of dispute between the doctor and Rhonda O'Shea. The court accepted Rhonda O'Shea's version of these events, including her claim that she had told Dr Sullivan about her post-coital bleeding before August 1988. The court treated Rhonda O'Shea as a more credible witness than Dr Sullivan for these purposes. Rhonda O'Shea was variously described as a witness who 'did her best to tell the truth', who 'does not dramatise matters but does make her point' and as a person of 'much personal charm and a lively, attractive spirit'. Dr Sullivan, by contrast, was described as 'acutely embarrassed over what has occurred and [seeking] to escape or at least minimise the blame which attached to her'. Whilst it is not unusual for a court to favour one witness over another in this way, in this case the court's preference for the plaintiff's evidence also involved a rejection of the accuracy of Dr Sullivan's clinical notes. This rejection has been questioned, on the basis that Dr Sullivan's notes were far from sketchy or imprecise, but rather were detailed and of 'well above average standard ... [providing] a coherent medical story'. One consequence of the O'Shea case therefore seems to be that a doctor cannot safely assume that her or his notes of a consultation, which the doctor believes to be detailed, accurate and representative of what transpired in that consultation, will necessarily be accepted by a court as the true version of events.
Burnett v. Kalokerinos ('the Burnett case')

The facts and the court's findings

Cecily Burnett lived in the NSW country town of Bingara. After the birth of her second child in June 1991 she experienced heavy vaginal bleeding. She consulted the town's only doctor, Dr Archivides Kalokerinos, about this bleeding a number of times. In October 1991 he referred her to a specialist obstetrician and gynaecologist in Tamworth for further investigation of the bleeding. Cecily Burnett told Dr Kalokerinos that it would be difficult for her to travel to Tamworth to keep this appointment. She did not have a car, public transport services were too infrequent for her to be able to visit Tamworth without staying overnight, and she could neither afford to pay for overnight accommodation nor for someone to look after her two children while she was away. She asked Dr Kalokerinos instead to make an appointment with a specialist in Inverell, a closer town which she could visit more easily. She claimed that he refused on the basis that he did not work with doctors in Inverell. She also claimed that, after she had emphasised the difficulties she would have in going to Tamworth, he reassured her by advising her just to 'keep an eye on [the bleeding] and see if it settles down'. Dr Kalokerinos denied this version of events. Although he had no memory of the October 1991 consultation, he relied on his ordinary course of practice and said that he would never have acted in this way. Cecily Burnett did not keep the appointment with the specialist in Tamworth. Her vaginal bleeding continued. She did not seek further medical attention in respect of this bleeding until July 1992, when she saw a different doctor who diagnosed cervical cancer. Beginning in October 1992, she underwent radical surgery and radiotherapy, with bad side effects including reliance on colostomy and ileostomy bags, severe pain and extreme weight loss.

Cecily Burnett successfully sued Dr Kalokerinos in negligence in the Supreme Court of New South Wales. Spender AJ delivered the court's judgement on 22 March 1995. In upholding her claim, the court held that Dr Kalokerinos had breached the duty of care he owed to the patient by failing to make appropriate alternative arrangements for her to have a specialist examination. This failure had resulted in a delay in diagnosing her cancer, with serious and long term effects on her health which would have been avoided if the cancer had been detected and treated by hysterectomy before February 1992. The court awarded Cecily Burnett over $300 000 in damages.

An appeal against the decision of Spender AJ will be heard by the NSW Court of Appeal in November 1995.
Discussion

The result in this case also has been strongly criticised. The main criticism alleges that the case represents a further and undesirable extension of the 'duty to refer' which emerged in the O'Shea case. It has been argued that not only has the law begun to place excessive and indiscriminate pressure on general practitioners to refer their patients to specialists, it now also requires those general practitioners to go to unreasonable lengths to ensure that those patients take up their referrals. In the words of the then-Federal president of the Australian Medical Association:

Has it come to the stage where not only do doctors have to diagnose the problem and give adequate advice, but does this mean they also have to physically ensure that patients carry out that advice? . . . It's time that we realised that patients have rights, but they also have responsibilities. If a patient is given advice by a doctor then an adult patient, you would think, has a responsibility to see that they follow that advice.  

The court in the Burnett case specifically examined the issue of whether Cecily Burnett had abdicated her responsibilities as a patient. It was argued in court that she had been contributorily negligent because, after Dr Kalokerinos had told her she should see a specialist, she failed to ensure her condition was properly investigated without delay. Had she done this within four months of the October 1991 consultation, her cancer would have been detected and treated at a stage where the serious harm she had suffered could have been avoided. The court accepted that Cecily Burnett had understood that vaginal bleeding could be a sign of cancer, but concluded that, because abnormal bleeding can be a sign of other things as well, inaction in the face of this knowledge was not enough to have made her partly responsible for the harm she suffered. This was because she had not been warned by Dr Kalokerinos 'that there was a potential of a cancer'. Accordingly, she was not 'fixed with a sufficient appreciation of the dangerous nature of her condition so as to put her, as a reasonable person, on notice that action should be taken and that she needed, without delay, to have her condition properly investigated, at an appropriate level of medical expertise'.

This reasoning and conclusion was similar to that of the court in the O'Shea case, where it was also alleged that the patient had been contributorily negligent. Rhonda O'Shea's alleged contributory negligence lay in her failure to obtain further medical advice prior to December 1988 about her continuing bleeding. The court rejected that argument on the basis that Rhonda O'Shea was not made aware by Dr Sullivan of how serious her situation might be:

There was no carelessness or unreasonable delay on the part of Ms O'Shea. It is good that she had the initiative to seek a second opinion. She had not been warned of a potential cancer problem and no one had told her the problem was urgent and it had not been so
treated by Dr Sullivan. Ms O'Shea as a lay person cannot be expected to have had the
knowledge possessed by the medical profession.\textsuperscript{75}

Compare the result in \textit{Locher and Another v. Turner}, an unreported decision of the Court of Appeal of Queensland delivered on 21 April 1995. The case involved an unsuccessful appeal against a finding that Dr Turner, a general practitioner, had been negligent for failing to conduct proper investigations of her patient’s symptoms of colon cancer, and thus failing to diagnose the cancer until it was too late for successful treatment. The doctor's negligent behaviour included her failure to ask the patient, Mrs Locher, during two consultations in November 1992 whether she was still experiencing rectal bleeding. The patient had complained of this bleeding at earlier consultations in May and September 1992, but she did not mention in the November 1992 consultations that the bleeding was continuing. The court held that Dr Turner should have realised that this failure may have been because the patient was 'reticent about details of her physical condition',\textsuperscript{76} and also warned that '[i]t ought not to be assumed that a lay patient would appreciate the potentially lethal significance of a condition causing persistent bleeding from the bowel.'\textsuperscript{77} Significantly, however, the court also held that Mrs Locher's damages award should be reduced by 20% because her failure to tell the doctor about her continuing rectal bleeding amounted to contributory negligence.\textsuperscript{78} This seems to be the first Australian case in which a patient has been held to be partly to blame for the consequences of her doctor's negligence. It therefore is an important case, because it shows that Australian courts may in the future be more willing to hold patients, as well as doctors, legally responsible for behaviour affecting the outcome of their medical treatment.

A further response to the assertion that the doctor in the \textit{Burnett} case was held to an unreasonably high standard is that Dr Kalokerinos himself conceded in his evidence that, had he in fact behaved in the way alleged by Cecily Burnett, he would certainly have been negligent. He went even further and described such behaviour as 'morally indefensible'.\textsuperscript{79} Unfortunately for him, the court did not accept his claim that he had not engaged in such behaviour. The court favoured Cecily Burnett's version of events; like Rhonda O'Shea, she was considered to be a credible witness despite some deficiencies, inconsistencies and contradictions in her evidence.\textsuperscript{83} Interestingly, her 'obvious detestation' of the defendant, to whom she referred as 'Killer Kalokerinos', was considered by virtue of its frankness to enhance rather than detract from her credibility.\textsuperscript{81} The court was impressed by the forcefulness of her personality, describing her as articulate, intelligent and resourceful, and was persuaded that her evidence was substantially accurate and truthful. Her case was further supported by the corroborative evidence of two other witnesses who were her friends.

Dr Kalokerinos' case was not assisted by the standard of the clinical notes he had made concerning Cecily Burnett's treatment. Unlike the general practitioner in the \textit{O'Shea} case, Dr Kalokerinos kept extremely poor records about his patients, their complaints,
symptoms, treatment, medication prescribed and referrals made. Of the 23 visits made by Cecily Burnett to Dr Kalokerinos while he was her doctor, he was able to produce written notes in respect of only six of those consultations. The court attributed this at least partly to the large numbers of patients (as many as 72) seen each day by Dr Kalokerinos. The picture painted by the court of the defendant's medical practice was of an extremely busy surgery in which Dr Kalokerinos was the sole practitioner, where he spent on average only around 7.5 minutes seeing each patient, and where consultations were often interrupted by telephone calls. In the case before the court, 'the press of a very busy practice' unfortunately resulted in Dr Kalokerinos falling below the standard of care legally required of a general practitioner. His response to Cecily Burnett's situation was described by Spender AJ as 'humanly understandable' in the context of his busy practice, but 'not in the terms of the law of negligence excusable'.

The result in the Burnett case therefore sends an important warning to medical practitioners: that patient care must not be compromised as a result of the time constraints under which doctors carry out their professional duties. This warning may have particularly difficult implications for overworked sole practitioners in rural communities who feel obliged to continue to provide a service to all in need. The warning also serves as an important reminder, however, that all patients (including those in rural communities) are entitled to expect a basic minimum standard of service from their doctors.

Maffei v. Russell and Another ("the Maffei case")

The facts and the court's findings

Unlike Rhonda O'Shea and Cecily Burnett, Nadia Maffei did not succeed in the action she brought against her doctors in respect of their allegedly negligent failure to diagnose her cancer at a time when it could have been treated successfully.

In early 1992, when she was 31 years old, Nadia Maffei consulted her general practitioner about a lump she had recently noticed in her left breast. He referred her to Mr Ian Russell, a surgeon and oncologist who specialised in the diagnosis and treatment of breast cancer. She first saw him in March 1992. At that time she was breastfeeding her first child. He examined her and diagnosed the abnormality as a blocked milk duct. She claimed that she asked him whether he was going to perform further tests to confirm this, such as a needle aspiration, biopsy or mammogram, and that he told her this was unnecessary and advised her to return in about two months' time. Nadia Maffei saw Mr Russell again in May 1992 to have the lump checked. She claimed that she told him she was worried that it could be
cancer, because her mother had suffered breast cancer at the age of 38 and because she was on an IVF programme which involved taking hormones. Mr Russell again examined her, she claimed that she again asked him if he would perform a needle aspiration or a biopsy, and he again told her she had a blocked milk duct which would subside by itself.

Still worried that she had cancer, in June 1992 Nadia Maffei consulted another doctor, Mr Donald MacLeish, a general surgeon who specialised in the diagnosis and treatment of breast cancer. He had successfully treated her mother's breast cancer. Mr MacLeish performed a needle aspiration, examined the contents of the syringe and disposed of them without sending them for pathological analysis. He told Nadia Maffei that she had inflamed mammary ducts and that this benign condition would settle by itself. She consulted him again a number of times that year.

Nadia Maffei returned to Mr Russell for the third time in November 1992 and told him the lump was still there. He examined her again. She claimed that she repeated her concerns about breast cancer and asked him if he would perform a needle aspiration. He again told her that she only had a blocked milk duct which would go away by itself, and that there was no need to do anything further.

In April 1993 Nadia Maffei consulted Mr Russell again about her breast lump. At this time she was 12 weeks' pregnant. Thinking her breast abnormality could be attributed to her pregnancy and hoping to reassure her, Mr Russell performed a needle aspiration. The results of this test and a subsequent biopsy revealed the presence of cancer. Nadia Maffei underwent a mastectomy and removal of glands. This surgery did not prevent her cancer from spreading. She terminated her pregnancy on medical advice, and subsequently underwent chemotherapy and radiotherapy. Despite this treatment the cancer eventually spread to Nadia Maffei's brain, spine, liver and lungs. She died on 12 July 1995, four months after a jury dismissed the negligence action she brought in the Supreme Court of Victoria against Mr Russell and Mr MacLeish.

Discussion

In her unsuccessful legal action, Nadia Maffei alleged that both specialists had negligently misdiagnosed the cause of the abnormality in her breast, by virtue of their failure to test or make arrangement for proper testing of the abnormality. She contended that Mr Russell had been negligent in the consultations of March, May and November 1992, because he had merely examined her and had failed to ensure that investigative tests were performed. She contended that Mr MacLeish had been negligent in the consultation of June 1992, because he had not sent the fluid he removed from her breast for pathological examination. She asserted that at the time of each of these four consultations cancer was already present in her breast, that had further investigations been undertaken the cancer would have been
detected, and that had the cancer been correctly diagnosed on any one of these occasions she would have been treated at a sufficiently early stage of the disease for treatment to have been successful.\textsuperscript{84}

Both defendants countered that, at the time of each of these consultations, the breast abnormality of which Nadia Maffei complained was benign. Their diagnoses at these times therefore had been correct, and her condition had not warranted the further investigations she claimed should have been undertaken. Had these investigations of the abnormality been undertaken, the defendants argued, they would not have revealed cancer.\textsuperscript{85} In support of their assertion that Nadia Maffei’s breast abnormality had been benign at these times, they challenged her claim that she had presented at each consultation with the same, defined breast lump. They claimed instead that the nature and site of her breast abnormality had changed over the course of these consultations, and further that this changing abnormality was different from (and not a sign of) the cancer which was subsequently diagnosed in her breast.

As this case was decided by a jury, there is no judgement setting out the reasons why Nadia Maffei’s case failed. Certain inferences may be drawn, however, from this result and from the contents of Ashley J’s direction to the jury.\textsuperscript{86}

The jury obviously was not persuaded by the arguments made on Nadia Maffei’s behalf. This could simply have been because it found her version of events and description of her symptoms less credible than that of the defendants. As noted above, it is open to a court to prefer the account of one witness over another. The possible reasons for such preference, however, deserve exploration. If the jury did consider Mr Russell and Mr MacLeish to have been more credible than Nadia Maffei, to what extent might the jury have been influenced by the fact that both these doctors were eminent, highly experienced and well-respected specialists in the treatment of breast cancer, whereas Nadia Maffei was ‘merely’ a patient? This point emerges from a number of passages in the judge’s address to the jury:

\begin{quote}
[Counsel for Nadia Maffei] . . . said you had heard a lot about the credentials and reputation of the defendants, but reputation and title didn’t make up for the failure to operate properly in the surgery. He submitted the way in which the defence was run was that the court was dealing with a medical elite, that there was an arrogance and condescension about anyone who dared to criticise a surgeon.\textsuperscript{87}

As to mammography, [counsel for the defendants] said it was Mr Russell who set it up in Victoria, and he invited you to consider that the plaintiff’s doctors were in effect trying to tell Mr Russell, the man who had set up mammography, what ought to be done.\textsuperscript{88}
\end{quote}
Unfortunately it is impossible to determine to what extent the jury adhered to the following warning by Ashley J:

It would be a wrong course to rely upon Mr Russell's reputation, such propensity for accuracy as reputation might imply, to decide the facts of the present case.  

It is sometimes asserted that, in assessing the credibility of witnesses in medical negligence cases, courts tend to treat plaintiffs' evidence with undue generosity because of the 'sympathy value' of their situation. This assertion has been made, for example, in connection with the courts' findings in the *O'Shea* case and the *Burnett* case. Like Rhonda O'Shea and Cecily Burnett, Nadia Maffei was a young woman afflicted by invasive cancer, and who had suffered the terrible effects of this disease and its treatments. At the time of trial Nadia Maffei faced the prospect of her own death within months. She also faced the consequences of that death for her husband and young child. It is difficult to imagine a plight more likely to evoke sympathy in either judge or jury; yet Nadia Maffei's legal action failed. Any sympathy the jury may have felt for her did not materially assist her case.

An additional factor contributing to the failure of Nadia Maffei's legal action may have been that the jury found the expert medical evidence adduced in support of her case less persuasive than that supporting the defendants' case. A range of expert witnesses gave evidence before the court, some supporting Nadia Maffei's claims and some supporting the claims of Mr Russell and Mr MacLeish. The jury was faced with a complexity of conflicting evidence concerning the kind of breast abnormality with which Nadia Maffei had initially presented, the appropriate management of such an abnormality, and the likely course of development of her breast cancer. This complexity arguably operated in the defendants' favour and arguably was used to great effect by counsel for the defendants. The jury may also have been influenced by the assertion, made by counsel for the defendants, that the expert evidence favouring the plaintiff was less valuable because none of the plaintiff's expert witnesses were surgeons, despite Ashley J's warnings that this claim was not necessarily true.

Two further points arise from the *Maffei* case. The first is that Ashley J's charge to the jury contains a strong reminder that in Australia it is the court, rather than the medical profession, which ultimately determines the standard of care demanded of a medical practitioner:

Evidence of practice may be used by you as some guidance to what is the reasonable care to be exercised by a reasonably competent medical practitioner of the class in which each defendant was. But could I emphasise again, it is for you to determine what a reasonably competent medical practitioner should have done in the particular circumstances of this
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...case. Practice can be a guide as to what is proper, non-negligent conduct, but you have to
determine, in the circumstances of the case, as you are satisfied they were presented to Mr
Russell and Mr MacLeish, at times of the four consultations, what each of them should
reasonably have done.93

Secondly, this case may indicate that general practitioners have more to fear from the
courts than do specialists, at least where negligence is alleged in respect of misdiagnosis.
The court in the O'Shea case placed great emphasis upon the need for a doctor to
undertake thorough and rigorous investigation whenever a patient presents with symptoms
that indicate the possibility of cancer, no matter how remote that possibility. In the O'Shea
case, the court held that the general practitioner could and should have discharged her
obligation to exclude the possibility of cancer by referring the patient to a specialist. In the
Maffei case, the court arguably did not place the specialists to whom Nadia Maffei was
referred under a similarly rigorous duty to exclude the (extremely remote, as they saw it;
much less remote, as Nadia Maffei saw it) possibility of cancer. Moreover, the court in the
Maffei case arguably subjected the defendant doctors to much less critical scrutiny,
concerning the possible effects of a very busy practice upon the quality of attention offered
to the plaintiff, than did the court in the Burnett case. Mr Russell seems to have been no
less busy than Dr Kalokerinos - on the morning of the March 1992 consultation, Mr
Russell saw 35 patients, and Nadia Maffei was one of 5000 patients he saw that year94 -
but there seems to have been no exploration of whether this may have detrimentally
affected the standard of medical care received by Nadia Maffei.
Future Directions? The Aftermath of the Aftermath of Rogers v. Whitaker

The claim that Australian law has begun to treat doctors with unacceptable severity is simplistic and misleading. It certainly is true that the legal rules articulated in Rogers v. Whitaker and applied and developed in subsequent cases - including the Woods case, the O'Shea case, the Burnett case and the Maffei case - have begun to subject doctors' behaviour to greater legal scrutiny. It does not follow, however, that increased scrutiny necessarily is undesirable.

One effect of increased scrutiny has been a heightened awareness amongst both the medical profession and the wider community that doctors are at risk of being sued successfully by their patients. This awareness unfortunately has been accompanied by a high level of public misinformation and misunderstanding concerning the way the law has developed in each of the high profile cases discussed in this paper. A better understanding of the nature and real extent of doctors' legal responsibilities would be desirable. It would enable doctors to identify more accurately the ways in which it would be prudent for them to modify aspects of their day-to-day practice to minimise the likelihood of legal actions. This would go some way towards dispelling the 'global and unfocused anxiety' within the medical profession about the possibility of litigation. A better understanding of the relevant legal rules would also enable doctors and their legal representatives to mount more selective, and thus more sophisticated and effective, arguments about the way the law is or is likely to affect medical practice detrimentally. This would in turn facilitate more informed public debate on the important question of whether the law is developing appropriately in this area.

Essential to a more complete understanding of the relevant law is the recognition that successful negligence actions by patients against their doctors are relatively rare in Australia. Despite frequent claims to the contrary, Australia is not experiencing a medical malpractice 'litigation crisis' of the kind seen in the United States. It is true that there have been significant increases in the past five years in the subscription rates for indemnity insurance paid by many Australian doctors to medical defence organisations. This dramatic rise seems to have been caused, however, largely by the abandonment by most medical defence organisations in 1989 of the long-standing 'principle of mutuality'. Under this principle, all Australian doctors had paid the same subscription rates regardless of the level of risk associated with their area of medical practice. It was abandoned in favour of a system which differentiates between different types of medical practice and charges higher subscription rates to members of higher-risk practice groups. There seems to have been two main reasons for the abandonment of mutuality and resulting rise in
many premiums: the realisation by medical defence organisations that their subscription rates had for some time been too low to provide adequate funding for liabilities; and the entry of 'predatory' insurance companies into the low-risk end of the medical insurance market, which placed financial pressure on medical defence organisations to minimise subscription rates they offered to members of low-risk practice groups.97

A major study has suggested that there is insufficient publicly available data in Australia concerning either the incidence or the fate of legal claims commenced against doctors.98 It has been estimated, however, that only around 5 - 10 per cent of people who suffer injuries where a doctor was probably negligent commence legal actions, and as few as 1% of all such claims result in a full hearing in court.99 Even if a case is heard in court, success for a plaintiff is far from guaranteed - as the Maffei case dramatically illustrates. It remains to be seen whether the high profile cases discussed in this paper will encourage significantly greater numbers of patients harmed as the result of medical treatment to sue their doctors in negligence. The substantial financial costs associated with initiating and running a medical negligence action are likely to continue to deter many potential plaintiffs.100 Even if many more patients did sue, it seems unlikely that a large percentage of them would succeed in their legal actions. Although many of the recent legal developments discussed in this paper may be characterised as 'pro-patient', they have not been uniformly so. Whilst welcoming those recent changes in the law that will assist patients seeking to establish negligence, plaintiffs' lawyers argue that the playing field is nonetheless still far from level, and that the legal rules governing medical negligence actions continue unfairly to favour defendants over plaintiffs.101

Concerns have been expressed that the law's increased attention to, and redefinition of, the legal responsibilities of doctors will lead to a situation where doctors are forced to practice 'defensive medicine' to protect themselves from legal claims. If such a situation is one where doctors protect themselves by taking more time and care with their patients, to ensure that they discharge their duties in respect of providing information, diagnosis and treatment, this would not be an undesirable result:

... defensive medical practices may... be regarded as good clinical practice and seen as a positive effect of the threat of litigation, where these actions result in better informed patients, more detailed explanations of diagnosis, treatment and the risks involved, improved patient record keeping, more appropriate referral for tests, follow-up consultations or preventing doctors operating outside their field of competence.102

If, however, such a situation is one where doctors protect themselves by regularly conducting tests and procedures which are not medically justified, but are carried out primarily or solely to avert liability for medical negligence,103 this would be an undesirable result. It would be undesirable because behaviour of this kind arguably involves doctors
compromising their professional duties towards their patients, by defending their own personal interests where their obligation is rather to protect and advance the interests of their patients.\textsuperscript{104} It is to be hoped that the medical profession will strenuously resist any tendency by, and pressures placed upon, its members to behave in this way.

It is also to be hoped that the legal profession will resist any tendency to pursue or defend doctors in an overly aggressive and confrontational manner. In recent years Australian law has begun to give greater recognition to the rights of consumers of all kinds of goods and services, not just consumers of health care. This rise of consumerism has coincided with greater pressures on law firms to function as profitable businesses. Both trends have led to fears that Australian lawyers increasingly will solicit prospective clients, and encourage them to proceed with litigation which is financially rewarding for their legal representatives but not necessarily in the best personal or financial interests of the clients themselves. Lawyers on both sides of medical negligence cases - those who represent plaintiffs and those who represent defendants - have been accused of engaging in behaviour which encourages litigation, exacerbates its adversarial nature, discourages out-of-court settlement of claims,\textsuperscript{105} and generally heightens hostility between the parties.

There is growing recognition that aggrieved patients and the doctors who treated them are in many cases best served by alternatives to litigation.\textsuperscript{106} This recognition has led to the recent establishment in Victoria, Queensland, New South Wales and the Australian Capital Territory of independent statutory health complaints authorities which are empowered to investigate and resolve consumer complaints about health care services.\textsuperscript{107} Importantly, these health complaints authorities facilitate and favour the resolution of complaints through conciliation in cases where this is appropriate.\textsuperscript{108} If a complaint can be resolved in this way at an early stage, and litigation thereby can be avoided, both parties can be saved considerable time, money and personal stress. The extent to which aggrieved patients will use and be satisfied by these new complaints mechanisms remains to be seen.

It does seem that recent legal developments are placing doctors in a situation where they have new and increased responsibilities. Changes in the legal rules relating to the standard of care to be met by doctors have changed the legal obligations of doctors in a way that will subject their behaviour to greater critical attention from outside the profession. Doctors arguably also have some responsibility to respond to these recent legal changes constructively, by helping identify how the law can develop in a way which nurtures, rather than harms, the doctor-patient relationship and thus enhances the quality of care patients receive from their doctors. It is not only doctors, however, for whom change is bringing new obligations. There are signs that the law is beginning to recognise that patients have responsibilities, as well as rights, in respect of the medical treatment they receive. It is also increasingly clear that the legal system itself has assumed perhaps the most onerous responsibility of all - the responsibility to develop and apply legal rules in a way that is fair to both patients and doctors.
Endnotes

8. This invariably will be the case if the plaintiff is the doctor's patient, because by accepting a person as a patient the doctor will have assumed responsibility for the care of the patient. As to when the doctor will be under a duty to treat those who are not her or his patients, see *Woods v. Lowns and Others*, discussed below.
10. The duty of care owed by a doctor to her or his patients is a 'single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgement': *Rogers v. Whitaker* at 483 *per* majority, quoting *Sidaway v. Governors of Royal Bethlem Hospital* [1985] AC 871 at 893 *per* Lord Diplock.
11. *Rogers v. Whitaker* (1992) 175 CLR 479 at 489 *per* majority; see also at 492 *per* Gaudron J.
14. (1992) 175 CLR 479 at 490 *per* majority; see also at 493 *per* Gaudron J. It is not clear whether the High Court regarded the risk of sympathetic ophthal mia as material because any reasonable person in the patient's position - as a person having sight in only one eye - would have wanted to know about the risk of losing sight in that eye; or because this particular patient had made her special concerns about her good eye known to the doctor, and thus he
knew or should have known that she would have wanted to know about the risk. See further at 491 per majority.

15 ibid at 493 per Gaudron J.

16 ibid at 489-90 per majority.

17 ibid at 493 per Gaudron J.

18 ibid at 490 per majority.

19 Compare Gaudron J’s formulation of the therapeutic privilege exception, ibid at 494:

I see no basis for any exception or ‘therapeutic privilege’ which is not based in medical emergency or in considerations of the patient’s ability to receive, understand or properly evaluate the significance of the information that would ordinarily be required with respect to his or her condition or the treatment posed.

20 See ibid at 494 per Gaudron J, emphasis added:

... the duty of disclosure which arises out of the doctor-patient relationship extends, at the very least, to information that is relevant to a decision or course of action which, if taken or pursued, entails a risk of the kind that would, in other cases, found a duty to warn.

and ibid at 490 per majority, emphasis added:

... no special medical skill is involved in disclosing the [relevant] information, including the risks attending the proposed treatment.

21 ibid at 489 per majority, emphasis added:

... whether the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment...

22 See ibid at 494 per Gaudron J, footnote 54 (referring to Canterbury v. Spence (1972) 464 F 2d 772 at 781). Note that the Public Patients’ Hospital Charters that have been introduced in New South Wales, Victoria, Queensland, Western Australia and the Northern Territory all confer a right on public hospital patients to receive information about treatment that goes beyond a right to receive information about material risks. For example, clause 4 of the Queensland Public Patients’ Charter confers a right to ‘a clear explanation of your condition, proposed treatment and its potential effects’, further providing that:

A clear explanation of your condition, any tests you may need and the suggested treatment (including risk), likely outcome and alternative treatment, will be given to you in language and terms you can understand.
The Public Patients' Hospital Charters that are being developed in South Australia, the ACT and Tasmania will contain similar provisions. The Private Patients' Hospital Charter proposed by the Commonwealth Minister for Human Services and Health should also confer a similar right to receive information: see Dr C. Lawrence, *Press Release - Promoting Patients' Rights*, 25 June 1995.

23 In *Rogers v. Whitaker*, the plaintiff 'incessantly questioned' the doctor.

24 National Health and Medical Research Council 1993, *General Guidelines for Medical Practitioners on Providing Information to Patients* (prepared by the Health Care Committee of the NHMRC), NHMRC, Canberra.

25 ibid, p 1.

26 ibid, p 3.

27 ibid, p 6.

28 ibid, p 2.


30 ibid.

31 National Health and Medical Research Council, supra note 24, p 1.


33 *eg* Berger v. *Mutton* (unreported; District Court of NSW: Twigg DCJ; 22 November 1994 - risks associated with elective diagnostic surgery); *Bustos v. Hair Transplant Pty Ltd and Peter Wearne* (unreported; District Court of NSW: Cooper DCJ; 20 December 1994 - risks associated with cosmetic surgery). In both these cases, the court found in favour of the defendant doctors on the basis that: the patients were in fact warned by their doctors of the material risks associated with the medical procedures; and the patients would have undergone the medical procedures in any event regardless of the risks involved. See F. Campbell, 'Causation and the failure to advise of risks associated with medical procedures' (1995) 3 *Australian Health Law Bulletin* 65. A more recent case in which a plaintiff's allegation of negligent failure to warn of risks failed is *Karpati v. Spira* (unreported; Supreme Court of...
Moreover, in all these cases there has been a dispute between plaintiff and defendant concerning the information and advice that was actually provided. There was no such dispute in Rogers v. Whitaker.

One exception to this is a comment made by Wood J in Dunning v. Scheibner (unreported; Supreme Court of NSW; 15 February 1994). He was very critical of the defendant doctor's provision of treatment in circumstances where, inter alia, 'it was clear that the patient was not listening to the advice she was being given'. Arguably this comment supports the claim that doctors have a legal obligation to attempt to ensure the information they impart is received and understood by the patient.

(1992) 175 CLR 479 at 489 per majority; see also at 493 per Gaudron J.

ibid at 489 per majority.

[1957] 1 WLR 582.


Maynard v. West Midlands Regional Health Authority [1985] 1 All ER 635 per Lord Scarman.

(1992) 175 CLR 479 at 487, emphasis added.

ibid at 492, emphasis added. There is some disagreement amongst commentators as to whether this more emphatic rejection of the Bolam test in this context by Gaudron J means that her formulation of the law on this issue was different from that of the majority. The better position seems to be that the Bolam test was rejected in both judgements, but Gaudron J's rejection was clearer and more direct than that of the majority: '[w]hilst in essence Gaudron J agreed with the majority judgement, the language used by her Honour in the above passage is arguably more positive than the language used by the majority in its disposal of the Bolam principle' (Beach, D. 'Sons of Rogers v. Whitaker', unpublished paper presented at BLEC Advanced Medical/Legal Seminar, Melbourne, 25 August 1995).


Lloyds Bank v Savory & Co (1933) AC 201.
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46 Transcript of case, p 20.

47 ibid, p 37.

48 Paragraph 27(1)(h) of the Medical Practitioners Act 1938 (NSW) included the following within the definition of 'professional misconduct':

refusing or failing, without reasonable cause, to attend, within a reasonable time after being requested to do so, on a person for the purpose of rendering professional services in the capacity of a registered medical practitioner in any case where the practitioner has reasonable cause to believe that the person is in need of urgent attention by a registered medical practitioner.

The Medical Practitioners Act 1938 (NSW) was the relevant legislation regulating the registration of, and disciplinary proceedings against, medical practitioners in NSW at the time the events took place that were the subject of litigation in the Woods case. The Medical Practitioners Act 1938 (NSW) has since been repealed and replaced by the Medical Practice Act 1992 (NSW). This new legislation contains a provision, worded similarly to paragraph 27 (1)(h) of the old legislation, identifying a doctor's failure to render emergency medical treatment as a ground upon which disciplinary action may be based: see section 36 of the Medical Practice Act 1992 (NSW).

49 Badgery-Parker J referred to these facts as establishing sufficient 'physical proximity, circumstantial proximity and casual proximity' to impose a duty of care upon Dr Lowns. See transcript of case, pp 60-62. See further Gillies, R. 'Opening the Flood-Gates in NSW? Woods v. Lowns and Procopis', unpublished paper presented at BLEC Advanced Medical/Legal Seminar, Melbourne, 25 August 1995.

50 ibid, p 20. Moreover, diazepam was (and is) not registered for rectal use in Australia.

51 (1980) 2 NSWLR 542.

52 ibid at 562

53 ibid at 562-3, emphasis added.

54 See (1992) 175 CLR 479 at 487, footnote 34.

55 A helpful explanation of this terminology and of the different classes of abnormal Pap smear results is contained in Women's Health Information Resource Collective Inc. 1988, When A Pap Smear Isn't 'All Clear', Melbourne.
The court stated that proper practice would have required any slide indicating mild atypia to be reviewed by a second person; and that in 1988 (when Rhonda O'Shea's slide was examined) review by a senior scientific officer of the requisite skill and experience, rather than by a pathologist, would have sufficed - but 'if [the court] had to deal with the future position' the answer would be different.

(1994) Aust Torts Reports 81-273 at 61,305.

ibid at 61,305.

ibid at 61,305.

ibid at 61,297.

ibid at 61,305.

ibid at 61,298.

Macquarie Pathology Services Pty Ltd v. Sullivan; Sullivan v. Macquarie Pathology Services Pty Ltd (unreported; NSW Court of Appeal: Kirby P, Mahoney and Clarke JJA; 28 March 1995).

Black, F. 'Why the law is not fit to judge', Australian Medicine, Vol 6(14) 1 August 1994: 21:

...I think this raises serious questions for the Royal Australian College of General Practitioners which has struggled to have general practice recognised as a specialty. General practice is not a basis of knowledge that all specialists have and then move on from. It would be arrogant and inappropriate for a GP to rule on the 'reasonableness' of a specialist colleague's work and the converse holds true.

This general practitioner was Dr Catchlove, the doctor who Rhonda O'Shea consulted for a second opinion when she became dissatisfied with Dr Sullivan's management of her condition. Evidence from other general practitioners was not called by the defence. Dr Sullivan's legal representatives have indicated that this was because the reports they had obtained from other general practitioners also did not support Dr Sullivan's case.

Dr Sullivan told the court that she did not recall being taught this 'golden rule'. See (1994) Aust Torts Reports 81-273 at 61,297.

Black, F., supra note 64, p 21.

Recent examples of cases in which this occurred include Stacey v. Chiddey (1993) 4 Med LR 345 (NSW Court of Appeal) and X and Y v. Pal and Others (1991) 23 NSWLR 26. Note that causation tends to be particularly difficult for plaintiffs to establish in cases involving
allegedly negligent obstetric treatment: see Davis, S. 'Foetal Distress Negligence Cases' (1994) 2 *Australian Health Law Bulletin* 117; Hirsch, D. 'Medical Negligence - A Litigation Crisis?' (1994) 2 *Australian Health Law Bulletin* 105. Also note that where a doctor's allegedly negligent behaviour has involved a failure properly to inform a patient, it is necessary for the plaintiff to prove more than that the harm suffered arose by virtue of the medical treatment administered to the patient. It additionally must be shown on the balance of probabilities that the patient would not have consented to the treatment had he or she been properly informed: see most recently *Andrzej Domeradski by his tutor Robert Domeradski v. Royal Prince Alfred Hospital and Others* (unreported; Supreme Court of NSW: Abadee J; 11 May 1994).


70 ibid at 61,298.

71 Black, F., supra note 59, p 21.

72 This result may affect the wisdom of the following maxim, traditionally exposed by medical defence organisations (see Munro, D. 'General Practitioners Under Siege', unpublished paper presented at BLEC Advanced Medical/Legal Seminar, Melbourne, 25 August 1995):

No notes - no defence;
Poor notes - poor defence;
Good notes - good defence.

73 Dr. B. Nelson, reported in '$300 000 for woman who ignored her GP's advice', *Sydney Morning Herald*, 24 March 1995. See also comments made by Dr E. Weisberg (medical director of Family Planning Association); reported in Chapman, S., 'The first thing we do, let's kill all the lawyers' *310 British Medical Journal* 1090 (29 April 1995).

74 Transcript of case, pp 57-8.


76 *Per* Pincus and McPherson JJA.

77 *Per* Byrne J.

78 See also *Brushett v. Cowan* (1990) 69 DLR (4th) 743 (Newfoundland Court of Appeal, Canada).

79 Transcript of case, p 51.

80 ibid, pp 7-8 and 17-23.
81 ibid, p 17.
82 ibid, p 46.
83 ibid, p 56.
84 Direction to the jury, p 1190.
85 ibid, pp 1070 and 1086-7.
86 This direction, which runs to over 200 pages, summarises the expert medical evidence presented during the case, the evidence given by the plaintiff and the defendants, and the arguments made by each side.
87 Direction to the jury, pp 1227-8.
88 ibid, p 1226.
89 ibid, p 1060.
90 See Chapman, S., supra note 73.
91 Council for the defendants 'said that the plaintiff's case had been put too simply. He called it simplistic' [direction to the jury, p 1225]; counsel for the plaintiff submitted that the purpose of the defence 'had been to complicate what was in fact a simple case' [direction to the jury, p 1227].
92 See ibid, pp 1083 and 1226.
93 ibid, p 1069.
94 ibid, pp 1145 and 1230.
95 Doctors' fear of being subjected to legal processes was described in this way by Dr Paul Nisselle, Australasian Secretary of the Medical Protection Society and former President of the Victorian AMA, at a recent BLEC medical/legal seminar (Melbourne, 25 August 1995).
96 For some doctors in high risk groups, there has been more than a tenfold increase in subscription rates during this period: eg in 1987 obstetricians paid subscription rates of $1 500; in 1989, $4 996; in 1992, $13 250; and in 1993, $19 950: Tito, F. 1993, Review of Professional Indemnity Arrangements for Health Care Professionals: Compensation and Professional Indemnity in Health Care - An Interim Report, AGPS, Canberra [hereafter Tito Review - Interim Report], p 233 and footnote 536.
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97 ibid, pp 228-241.

98 ibid, pp 17-21. Note that the Review of Professional Indemnity Arrangements for Health Care Professionals, conducted by the Commonwealth Department of Human Services and Health, has experienced some difficulty in accessing relevant data held by medical defence organisations: see Tito Review - Interim Report, supra note 96, pp 17-20.

99 Hirsch, D., supra note 68 at 106; Tito review - Interim Report, supra note 96, p53.


101 Hirsch, D., supra note 68. Not surprisingly, defendants' lawyers tend to argue that the opposite is true.


103 ibid, p 6.

104 For comments on this ethical duty of doctors to place the interests of their patients above their own, see Breen v. Williams (unreported, NSW Court of Appeal, 23 December 1994) per Kirby P., at p 38 of transcript.

105 This accusation has been levelled particularly at defence lawyers and the medical defence organisations that instruct them. The criticism has been expressed forcefully by David Hirsch, a senior associate with Cashman & Partners (a leading Sydney plaintiffs' law firm):

Most medical defence organisations will admit that they fight hard. Obviously they want to give their members the best legal defence money can buy. But the covert agenda is to send a message to the public: 'If you want to sue a doctor, get ready for a rough ride'... Too often the defence in medical negligence cases is callous, pedantic and fixated on winning a war of attrition. The enemies in that war are the very people who have placed their lives and the lives of their loved ones into the hands of the medical profession - a profession that they have been taught to trust implicitly. One of the unseen victims in medical negligence litigation is the integrity and good name of the medical profession itself.

Hirsch, D., supra note 68, p 112.

106 ibid, p 112:

We should be less concerned with winning and losing the legal battle and more concerned with how to avoid litigation in the first place. Where it cannot be avoided we should make every effort to resolve the dispute early, sensibly and with compassion.

108 The Victorian Health Services Commissioner has suggested that the only cases which cannot be resolved anywhere but in an adversarial setting (*ie* by litigation) are:

- cases where there is a significant issue of legal principle at stake, which will have implications beyond this one case, where the parties cannot be expected to resolve this issue themselves, but an independent judicial adjudication will do so
- cases where there is a genuinely contested view of the facts that would support liability or no liability, and it is advantageous to have the evidence tested in court
- the complexity of the contested issues is such that there is no gain in efficiency or cost in referring complaints to some speedier or more informal adjudication process
- the amount of potential compensation is sufficiently high to justify (and absorb - if that is possible) the costs of litigation.

Newby, L. "Do We Have to Litigate - Complaints Mechanisms and their Future Direction" (unpublished paper presented at BLEC Advanced Medical/Legal Seminar, Melbourne, 26 August 1995), p 6.