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Précis Paper

Duty of Care and Medical Negligence

A discussion of duty of care and medical negligence, and how it is established whether or not there is a duty of care between a doctor and their patient, and whether it has been breached. Specifically, it will consider general principles, decided scenarios, and key cases including a recent Court of Appeal decision.

Discussion Includes

- **General principles**
- **Decided scenarios**
- **Key Cases**
- **Breach of duty and the standard of care**

Précis Paper

Duty of Care and Medical Negligence

1. **In this edition of BenchTV, Anna Walsh (Solicitor, The University of Notre Dame, Sydney) and Lee-Ann Walsh (Barrister, Frederick Jordan Chambers, Sydney) discuss duty of care and medical negligence, and how it is established whether or not there is a duty of care between a doctor and their patient, and whether it has been breached. Specifically, it will consider general principles, decided scenarios, and key cases including a recent Court of Appeal decision.**

General principles

Q: **We often assume that establishing whether there is a duty of care between a doctor and their patient is straightforward. After all, can't we just look to *Donoghue v Stevenson* and the High Court case of *Rogers v Whitaker*?**

Rogers v Whitaker (1992) 175 CLR 479

A: **Yes, the general duty has been established. *Donoghue v Stevenson* created a principle as to when we owe a duty to someone to take care in our acts and omissions, where it is foreseeable that they may cause them harm. Clearly in the doctor/patient relationship we are inviting the doctor to use their special skills to interact with us in a way where if not done correctly, could lead to a poor outcome. Rogers v Whitaker established that a doctor must exercise reasonable care and skill in providing medical services including examination, diagnosis, and treatment, as well as providing information and advice.**

Q: **So the general duty of care of a doctor arises by virtue of the person being a patient of the doctor. What about when the person is not a patient of the doctor? Are there instances where the doctor may still owe that general duty to take reasonable care?**

A: **Yes, there have been cases that have established a duty between a doctor and a person who is not their patient. A few categories have emerged from the case law. One category is that of an emergency. It's important to note at the outset that there is no positive duty to assist someone in an emergency. There may be an ethical duty to assist, but that is different to a legal duty.**

Q: **So, if a child is drowning in a pool, you are not liable for not jumping in to help them?**

A: Correct, but the position of the doctor may be different where they have the knowledge and skills to do something that could avert harm, and where the effort needed to do that something is so little. We have the decision in *Woods v Lowns*, where the court found that a local doctor had a duty to come to the aid of a child who was not his patient, but who was having seizures, because he was close by and had in his doctor's bag some medication that could have stopped the fitting and avoided brain damage. So proximity, and the consensus that it was appropriate in all the circumstances, established a duty of care in the case.

Lowns v Woods (1996) Aust Torts Reports 81-376

Q: I imagine some doctors might be wary of doing this in case they are sued for not providing adequate care in an emergency?

A: Yes, but the law provides a shield via Good Samaritan protections in the *Civil Liability Act*. So if a person comes to the aid of a person in an emergency and in providing that aid in good faith, causes harm, they will not be liable.

Sections 55-58, Civil Liability Act 2002 (NSW)

Q: What are the other categories?

A: A 'patient by proxy' is another one. This occurs where another person acts on the first person's behalf with a doctor. This arose in a case I was in where the wife, who was a patient of the doctor, made an appointment for her husband, who was not. She relayed a history and various symptoms and concerns and on the basis of that information, was told that it was not serious and he could wait for 2 weeks. He was dead within the week from a condition that could have been treated. Whilst the plaintiff was not successful in proving a breach of duty, the Court of Appeal affirmed that the duty did indeed exist.

Alexander v Heise [2001] NSWCA 422

Also, the sexual partners of a patient where the doctor is dealing with is an STD, and has knowledge of the specific individual likely to be harmed. These cases turn on proximity and involve challenging practical issues such confidentiality and public policy

BT v Oei [1999] NSWSC 1082; Harvey v PD (2004) 59 NSWLR 639

They also extend to procedures such as sterilization, where if they fail to achieve their outcome through negligence and conception and birth occur, it's not just the female patient who may be affected, but the father of the child who may have been known to the doctor when they performed the surgery.

McDonald v Sydney South West Area Health Service [2005] NSWSC 924

Q: **Let's say the woman was not married or in a relationship at the time of the procedure and conception happens some time later. How can the doctor owe a duty to a person in the future whom they do not know?**

A: **Good point. The duty to that father might not exist. They probably need to have been known to the doctor. For policy reasons, it probably cannot extend to a class of persons into the future who might have a sexual relationship with the patient who underwent the sterilization. It's far too open ended.**

Goodwill v British Pregnancy Advisory Service [1996] 2 All ER 161

Q: **And I assume another obvious one is the duty a doctor owes to an unborn child where they are treating the child's mother.**

A: **Yes, whilst the unborn child lacks legal personhood status, doctors have to put the politics aside because the reality is that they are treating two patients. The case law has long established that a duty of care can be owed to an unborn child but only acted upon after they are born.**

Watt v Rama [1972] VR 353; Lynch v Lynch (1991) 25 NSWLR 411

<u>Decided Scenarios</u>

Q: **So we have looked at the general principles of duty of care and its extension to persons who are not patients of the doctor, what are scenarios where the courts have determined the scope of the duty?**

A: **The scope of the duty will always reflect the particular circumstances of the case and the relationship between the parties. Rarely do medical negligence cases set a general principle, it's more often specific to the case which is what makes medical negligence**

challenging. It's never going to be a cookie cutting exercise. You will nearly always have to make the argument and join the dots.

Q: Yes. So cases provide guidance only. Having said that, are there are some decisions that involve common scenarios that come up time and again?

A: Yes. *Rogers v Whitaker* established that a doctor has a proactive duty to warn the patient of material risks, and that they have a reactive duty to discuss and disclose information about any special concerns the patient raises with them.

There is a Court of Appeal decision called King where it was established that a doctor needed to be up to date on information about a proposed treatment. In between discussing the treatment with the patient, new information had come in that raised concerns about certain risks.

South Eastern Sydney Area Health Service v King [2006] NSWCA 2

There is a degree of general application with a decision like this and in a sense it seems obvious, but it is the practical application of it to other scenarios where it raises questions.

Q: Yes I can imagine that a busy, small town rural GP will not have the resources or time to be actively updating their knowledge every day. Does the decision require active enquiries by the doctor?

A: Well this is where we have to make distinctions. I would expect that to be in contact with others doctors through organizations who take on the responsibility of updating knowledge is fair. This is very different to a tertiary hospital, where doctors are pushing boundaries and have access to up to date information more quickly.
Another decision that has wide application because of its commonality is *Thompson v Haesbroek*. I was involved with that case. The doctor was found to have a duty to refer the patient for further investigation and treatment. He had been treating the patient over a long period of time for depression, when in fact they had a serious underlying condition of the cervical spine. Diagnosed very late, by someone else who picked it up by chance, the patient suffered incomplete quadriplegia paraplegia.

Thompson v Haesbroek [2010] NSWSC 111

Q: I imagine doctors might have panicked with that decision, believing that they have to waste money and refer patients for all sorts of investigations to cover themselves?

A: Yes, the decision generated media attention when it was handed down. But you have to look at the particular facts. Putting this patient's constant complaints down to depression when she had an emerging neurological condition is not adequate care. The court is not saying the doctor has to get it right the first time; in fact they can be wrong because some conditions are hard to pick up initially and their initial diagnosis might be quite reasonable. But when the patient keeps coming back to you with the same or worsening problems and you don't review the initial diagnosis, then referral for investigations and specialist opinion is hardly over the top.

Q: Are there any other scenarios you think are worth mentioning?

A: In a case called Sherry, it was found that in a hospital, there is a need to ensure, there are appropriate staffing levels to provide an adequate standard of care.

Sherry v Australasian Conference Association (trading as Sydney Adventist Hospital [2006] NSWSC 75

Q: What about section 42 of the Civil Liability Act which provides a shield for public authorities where their functions are limited by the financial resources that are available to them? How does this case affect that?

A: Yes, there is a caveat here. Sherry involved a private hospital as opposed to a public hospital. As you say, section 42 provides a shield for public authorities, but there are no cases that I am aware of where it has been successfully deployed as a defense in a medical negligence context. I have seen it pleaded as part of a defense in public hospital cases. So we will wait and see.

A Court of Appeal Decision from this year involving a local council considered and applied this section and the Court held that it can look at unallocated funds but cannot challenge the general allocation of resources to that authority. In the particular case, bank statements from the council were used to consider the amount of their unallocated funds.

Weber v Greater Hume Shire Council [2019] NSWCA 74

Q: So before closing off this section, what are the key considerations for practitioners when establishing duty of care and is scope in medical negligence?

A: They need to focus on the relationship between the doctor and the person; the service provided by the doctor (or not provided as the case may be); and what part did the doctor have in causing the injury. Obviously lawyers must do legal research to find any new cases that fit or are similar to their scenario.

Q: So it seems like sometimes you need to look at duty, scope and causation together rather than separately?

A: Yes. Sometimes it is intertwined and you have to think broadly and really focus on your particular case.

<u>Breach of duty and the standard of care</u>

Q: So now we have established that there is a duty of care, and considered cases that have decided on its scope, I want to ask about how we prove the breach, and any up to date cases authorities we can use.

A: Proving breach of duty of care in a medical negligence case is all about trying to have an uncontested factual scenario upon which experts are called to give their opinion about what is widely accepted as being competent professional practice pursuant to section 50 of the Civil Liability Act.

Q: How does a plaintiff fare when there is a he said/she said situation?

A: As a plaintiff lawyer, I tended to avoid cases where there is a contest about the underlying scenario and the doctor has contemporaneous written records to support their version of events. But certainly you can make something of cases where there is an absence of medical records and where the plaintiff's version of events seems logical and fits with what is known about their condition but there is risk.

Q: When it comes to measuring what is reasonable, how does section 50 operate? That's the section that says that the defendant is not negligent where they act in accordance with what is widely considered to be competent professional practice in Australia. How do you recommend approaching this aspect of case preparation?

A: If you read the section, there are a couple of caveats that are important to remember. Firstly, a widely held opinion need not be universal; and secondly, the court can dismiss an opinion that meets that criteria, but which the court determines is "irrational".

The first interpretation of section 5O by the courts was in the case of *Halverson v Dobler*, which was run out of Maurice Blackburn. The Court of Appeal interpreted section 5O as a statutory defense.

However more recently in 2018, the Court of Appeal has confirmed that it is more than simply a defense. If the defendant establishes the preconditions in section 5O, then this creates the standard of care, subject to the court finding it to be irrational.

In addition, the Court of Appeal held that there can be more than one widely held body of peer professional opinion that is inconsistent with each other, and this will not necessarily result in a finding that one is irrational. The conclusion that an opinion is irrational will be rare and the Court said it would be an exceptional thing to do.

On a practical level, the Gould decision also noted that if the plaintiff believed that the defendant's expert opinion evidence rose to the level of being irrational, it should probably be raised in a reply to the defense to put the issue on the table, so to speak.

Dobler v Halverson [2007] NSWCA 335; South Western Sydney Local Health District v Gould [2018] NSWCA 69

Q: So Anna, what are you final observations on duty of care and proving breach?

A: Final observations are that proving duty and breach of duty in a medical negligence is not always straightforward. Whilst there is a decent body of case law that provides guidance as to when a duty will exit and what its scope is, the proving of negligence on the basis of expert opinion is challenging for a plaintiff. Only pursue cases that have good facts, where you can afford well regarded experts who understand how to show that their opinion about competent practice is widely accepted in Australia, and keep up to date on the law.

BIOGRAPHY

Anna Walsh

Lawyer/Academic, University of Notre Dame, Sydney

Anna Walsh is a lawyer specializing in Medical Law and Bioethics. An Accredited Specialist in Personal Injury law between 2006 and 2018, she spent 10 years as a Principal in the Medical Law department of Maurice Blackburn Lawyers representing plaintiffs in medical negligence litigation and families in coronial inquests. She has published widely in Medical Law, is a regular speaker at conferences, and is an author for Lexis Nexis' Practical Legal Guidance series. In 2011, she was named the Lawyer of the Year in Private Practice by the NSW Women Lawyers' Association. Anna is a PhD Candidate at the University of Notre Dame, completing a qualitative study on doctors and freedom of conscience. She teaches full time in the School of Law at University of Notre Dame in the subjects Advanced Torts, Mental Health Law, Remedies, Advocacy and Legal Research and Writing, and tutors in Bioethics in the School of Medicine. She has Honours degrees in Law and Nursing, a Master of Laws (res) from University of Sydney and a Master of Bioethics from Harvard Medical School.

Lee-Ann Walsh

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Lee-Ann Walsh was called to the Bar in 2012. Prior to this, she worked in the legal publishing, research and policy fields and was a tipstaff and Associate in the NSW Court of Appeal. She has appeared in key property and commercial cases in the High Court, as well as the Court of Appeal and Supreme Court and appears and advises in a wide range of commercial, corporate, property and planning disputes. She is also the editor of Hallmann's *Legal Aspects of Boundary Surveying* and a Adjunct Lecturer at the College of Law.

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Legislation

Sections 55-58, Civil Liability Act 2002 (NSW)