benchtv
a benchmark production

Précis Paper

Negligence and Consent in the Medical Profession: Part I

A discussion of the recent decision in *Tinnock v Murrumbidgee Local Health District* (No 6) [2017] NSWSC 1003

Discussion Includes

- Key facts
- Tort of battery
- Why did the plaintiff plead battery?
- Causation

Précis Paper

Negligence and Consent in the Medical Profession: Part I

1. In this edition of BenchTV, Anthony Bartley SC (Barrister, Elizabeth Street Chambers, Sydney) and Andrew Saxton (Principal, Meridian Lawyers, Sydney) discuss the recent decision in *Tinnock v Murrumbidgee Local Health District* (No 6) [2017] NSWSC 1003, why it has created quite some interest in both the legal and medical professions, and what both legal and medical practitioners can take away from the case.

Key facts

2. Mrs Tinnock developed a very substantial hernia as a result of repeated cesarean section deliveries of her children. There was no question that she needed surgery to repair the hernia.

3. She was referred to a consultant surgeon, Dr Payne, by her general practitioner. She believed that the surgery was to be carried out by the consultant surgeon Dr Payne. The consent form that she signed was a standard consent form supplied by Wagga Wagga Base Hospital.

4. Dr Payne had visiting medical officer rights there (what we call the right of private practice). He was also one of the surgeons who provided services to the public side of the hospital.

5. Mrs Tinnock was a public patient. The consent form that she signed had at the bottom of one of the pages a line that said in effect: 'I understand that this surgery might be performed by another doctor'. This was the linchpin that the case was decided upon.

6. Her surgery was then cancelled. By the time it was performed, a few months later, there had been a change in personnel, which meant that the registrar who ultimately performed the surgery had not actually been at the hospital at the time when Mrs Tinnock signed the consent document.

7. There was a judicial finding that the surgery was in fact performed by Dr Gundara. Dr Gundara was a third-year registrar, apparently with the skill to perform the surgery.

8. The case turned on Mrs Tinnock's evidence that she had understood that the surgery would be done by Dr Payne. She acknowledged that she had read the document that she had signed, but said that she had not realised the full implications of it.

9. Dr Payne was there, scrubbed, and providing assistance. There was no question over whether he was present or not. The paradigm case that the plaintiff argued was in effect that not only did she have to know the nature and character of what was being undertaken, she also had to know the identity of the person who undertook it.

Tort of battery

10. The key issue that arose in this case would most likely have been avoided if the public hospital, at the point of admission, had done more to inform the patient (like signing another form, which might state that the surgery might be performed by a registrar not a doctor), and if the consultant surgeon had visited his patient pre-operation to inform her that the registrar would be performing the surgery under his instruction.

11. If she had not agreed, a question would arise as a matter of law over whether there are two distinct areas of law relating to battery, because the law unbridled by considerations of public policy in the medical field is quite simple.

12. To avoid being guilty of the tort of battery, it must be shown that the person who has been trespassed upon knew two things:
    - firstly, what was going to be done, and
    - secondly, who was going to do it

13. Underlying the decision that His Honour Campbell J made in this case was an importation into the area of battery of the consideration of social utility. Social utility is one of the factors identified in s 5B of the *Civil Liability Act 2002* (NSW).

14. The question raised in this case is whether there are two categories of battery - that is:
    - the category in which the ordinary citizen can be sued for battery, and
    - an exceptional category that applies doctors

15. The battery case actually stops at the point at which the first surgical incision is made. It is important to understand what the trial judge found in terms of negligence because it underpins some of the findings he made in relation to the battery.

16. The key issue in the plaintiff's case, as to the precautions that a reasonable person in the position of either Dr Payne or Dr Gundara would have taken at the surgery, related to the placement of negative pressure drains. These drains are known to operate to drain fluids with minimal chance of infection.

17. The trial judge found that the failure to insert drains (which is done at the end of surgery) was a breach of duty of care – that is, it was a precaution that a reasonable person in the position of either Dr Payne or Dr Gundara would have taken.

18. A few experts gave evidence, some for the defendant, that it is a matter of choice whether or not to place a drain, and that there is then a question as to the period of time over which the drain is used.

19. This raises an important question for practitioners in this area, which is what the efficacy of s 50 of *the Civil Liability Act* is. S 50 states in effect that a doctor will not be found to be negligent if, although other people would have done it differently, the way he or she did it was in accordance with peer professional opinion.

20. That defence was pleaded in this case, as was the defence of inherent risk. The 50 defence was withdrawn during the course of the trial because it was not going to succeed in the face of the evidence given by all of the experts (that there was not a sufficient level of generality about the use or non-use of drains) to bring it within the ambit of s 50.

21. Almost all of the experts said they would have put in drains, so it is important to look subjectively, on a case-by-case basis, at a plaintiff's situation when considering the options of whether to drain or not. In this case, Mrs Tinnock was overweight and a smoker, which are factors that doctors ought to take into account when deciding use of drains.

22. The other issue that arose was over inherent risk. The inherent risk that was pleaded was the development of the body of fluid (seroma). But the seroma was not, in the end, the cause of Mrs Tinnock's problems. It was instead more the 'provider' of almost laboratory conditions for the development of infection. The inevitability of the seroma causing infection actually made it more imperative to use the drains.

23. So s 50 failed because there was not a level of particularity, and the inherent risk failed because the inherent risk that had to be addressed in this case was the risk of infection developing in the ideal medium for infection (which was the seroma).

24. The plaintiff was going to win in relation to the use of drains issue, so the plaintiff had a good case in negligence (under s 5B).

<u>Why did the plaintiff plead battery?</u>

25. The *Civil Liability Act* brought in a very restricted regime of damages – that is, the damages to which persons at common law would be entitled was probably restricted by about a third in general terms by the application of the *Civil Liability Act*.

26. The other advantage of suing in battery for trespass to the person is that it is a blameless tort. Negligence does not have to be proven. The battery was the incision with the scalpel. The negligence was not in the incision.

27. The issue was what happened at the end of the process, which was *initiated* by the (non-consensual) battery by the first surgical incision. An argument that there could not be a battery involved in the non-placement of the drain (in other words in the omission of doing something) fell to the wayside, because the case would not have gotten to the point of needing drains were it not for the initial incision.

28. The Court of Appeal was troubled by some words that were added after the *Civil Liability Act* was first drafted. S 3B, when it was first drafted, referred to sexual assault and intentional acts. That was then amended by the addition of the words 'done with the intention to cause injury', and did not have to be sexual in nature.

29. The general impression, at least in the profession, was that there had to be some degree of malice, but this does not appear to be supported by the authorities. There is no presumption in the criminal law that a person intends the natural consequences of their actions. The Crown still has to prove that there was *mens rea*.

30. But in a civil context, injury by way of the incision, at least in this case, could not be described as being accidental – it was clearly an intentional act.

31. Exactly what the words 'with the intent to cause injury' mean is unclear, but there seems to be no justification in the relevant authorities to read it as meaning to be done maliciously.

32. Mrs Tinnock did not know the identity of the person who was going to be making the incision. The judgment finds against her on that issue on the basis that she knew the nature and character of the act, and that it was going to be performed by a medical practitioner, and that was therefore a sufficient identification of the person to meet the test that emerged out of *Apostolopoulos v Hatzisarantinos t/as Omonia Constructions (No 3)*.

<u>Causation</u>

33. The case is also interesting for practitioners in terms of causation. The 'but for' test is contained in s 5D of the *Civil Liability Act*.

34. The question in this case was whether the infection, which had gotten to the life-threatening stage and led to the need for repeated attempts at remedial surgery, was something for which the failure to drain was a necessary condition.

35. Almost all conditions that require major surgery are unitary conditions; they cannot be separated into tortious and non-tortious parts. So the question was whether or not Mrs Tinnock would have reached the state that she was in when she arrived at the hospital had there been drains inserted.

36. The professional negligence list in the Supreme Court now requires the evidence-in-chief of all witnesses to be presented by way of a statement. In this case the statements were prepared well in advance, which led to a 'ping-ponging' exchange of statements, and led to some areas of inadmissibility, because these statements (which are normally prepared as the case unfolds) are often not prepared with sufficient enough an eye to what is and is not admissible.

37. A problem for the defendant arose over a discrepancy between statements of evidence made by Dr Payne. This sheds light on the degree of care required in the preparation of cases like these. Care needs to be taken with the preparation of statements at the initial stage so that the underlying assumptions put to experts are properly put. Practitioners need to ensure that doctors are careful in making their statements as to what they recall, and why they recall it.

38. Most doctors have a pretty good idea as to what falls short of a standard, and in the end, our system of litigation does tend to expose that. The giving and testing of evidence in Court seems to sort out the reality of what should have been done.

BIOGRAPHY

Anthony Bartley SC

Barrister, Elizabeth Street Chambers, Sydney

Anthony Bartley was called to the NSW Bar in 1972 and took silk in 1998. He has a wide practice; specialising in insurance, medical and professional negligence, personal injury, cases involving institutional child sex abuse and dust diseases. Anthony also has a wide ADR practice, working in mediation.

Andrew Saxton

Principal, Meridian Lawyers, Sydney

Andrew assists health professionals and organisations when responding to professional indemnity claims, disciplinary proceedings, Medicare investigations, fraud and overservicing claims. Andrew also appears as an advocate at coronial inquests. Andrew was recognised by Best Lawyers 2018 in the fields of Medical Negligence and Health & Aged Care Law, categories for which he has been recognised since the inception of the awards in 2008. Andrew was nominated as Medical Negligence 'Lawyer of the Year' in Sydney 2016. He was also identified in Doyles' Guide as a pre-eminent lawyer for Medical Negligence Lawyers (Defendant) NSW in 2016.

BIBLIOGRAPHY

Focus Case

Tinnock v Murrumbidgee Local Health District (No 6) [2017] NSWSC 1003

Cases

Apostolopoulos v Hatzisarantinos t/as Omonia Constructions (No 3) (2009) 7 DDCR 39; [2009] NSWDDT 6

Dell v Dalton [1991] 23 NSWLR 528

Griffiths v Kerkemeyer [1977] HCA 45; 139 CLR 161

Legislation

Civil Liability Act 2002 (NSW)

Law Reform (Miscellaneous Provisions) Act 1946 (NSW)