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Negligence and Consent in the Medical Profession: Part II

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

Discussion Includes

- Contributory negligence
- Damages
- Key takeaways for both legal and medical professionals

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Negligence and Consent in the Medical Profession: Part II

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.

Contributory negligence

2. Mrs Tinnock was a smoker, and overweight. She was a difficult patient with a range of complications.

3. There was question over whether or not there was scope for contributory negligence on the basis that Mrs Tinnock continued to smoke in the lead up to her surgery.

4. There was an undercurrent in this case, which was actually expressed by one of the doctors, that Mrs Tinnock was 'every surgeon's nightmare'. The focus by the defendant on how many comorbidities Mrs Tinnock had (not just the substantial incisional hernia, but also the obesity and the smoking, causing reduced circulation and greater susceptibility to infection) actually raised the standard of care necessary.

5. In this case, Mrs Tinnock did continue to smoke. If, for example, the doctor had said to her in February something along the lines of 'this is going to be major surgery, we will need to ensure the maximum degree of infection control, and you should really stop smoking', perhaps the case would have turned out differently. However, there was no evidence that any such advice was given to Mrs Tinnock.

6. The question of contributory negligence did not surface in this case. Under the *Civil Liability Act*, there can be no apportionment of responsibility, except if the harm is divisible.

7. It will rarely be the case that there is a divisible element in what is otherwise a unitary condition.

8. The plaintiff succeeded on the failure to drain, and on the failure to recognise the infection until only a few days before she was finally admitted to hospital (which the Court found to be a manifest failure). So there was a failure to investigate, and then to treat.

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9. It is commented upon in the judgment that by the end of this process the doctor-patient relationship between Dr Payne and Mrs Tinnock had clearly broken down. In the end, nothing turned on this observation.

10. If the judge, for example, had been satisfied that there had been a willful and deliberate decision not to do something, and it was motivated by animosity, that could certainly get into the area of exemplary damages.

11. The medical practitioner has to keep in mind the importance of communication when dealing with a difficult patient, and if a point is reached whereby the trust has broken down, then steps ought to be taken by that practitioner to have the patient managed by another practitioner in the hospital.

Damages

12. 38% was awarded for non-economic loss (pain and suffering). The psychological impact that was had upon Mrs Tinnock was significant. The assignment of percentages is still a mystery.

13. The harm that is done operates on the person as she was, so unless the defendant could prove that the plaintiff would have been in the same state (for example psychologically) as she was in to which their negligence was a contributing factor, they were always going to fail on this count.

14. Although there have been a few attempts to dismantle it, the principle that emerged out of *Dell v Dalton* (1991) 23 NSWLR 528 of 'a most extreme case' (rather than 'the most extreme case') still applies.

15. In *Dell v Dalton*, the Courts held that the use of the indefinite article 'a' allowed for questions of fact and degree to be taken into account in determining whether the severity of injury was such that the maximum sum was to be awarded. In areas of diminished earning capacity (economic loss), damages are capable of being rounded up in the calculation of them as a whole.

16. The approach to the rest of the damages is worth a good read because it is careful and detailed. The Court's approach to earning capacity in relation to damages in this case provide very good analysis. Its approach to the need for care in this case was focused on the necessary element being a *need created* rather than the *amount of care provided*. The Court applied the test that what is compensated for is the need that is created by the defendant's tort, which was assessed to be well beyond the threshold.

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17. It is also worthwhile for practitioners to look at the Court's approach in this case to dealing with the future in relation to paid care, and not care simply pursuant to *Griffiths v Kerkemeyer* [1977]. Often plaintiffs in cases similar to this will simply claim for the future commercial rates of X dollars per hour. In this case there was explicit evidence that suggested that the need for care was never going to abate, and that any amount awarded for the future would be spent on care.

18. This case is not the be all and end all of the ability of battery arguments to be run in public hospital patient claims – there may still be there scope for such arguments to be run in these claims – we will have to see.

Key takeaways for both legal and medical professionals

19. The medical profession is extremely good at ensuring that the award of qualifications is done properly. The accreditation system is a difficult one to get through, at least in Australia.

20. The patient has a fettered right to have the final say in who does what to them. It is important for doctors to bear in mind that simply following a formulaic approach to obtaining consent is when problems like the ones in this case have the potential to arise. The process of obtaining consent should rather be one that is always driven by communication.

21. In cases like this, it is important to remember not to assume that because someone is in the public health system, they have volunteered for whatever happens in the system. Here there was no question about the qualifications or skills of the relevant practitioners.

22. The idea that Mrs Tinnock consented to Dr Gundara because she must have known that it would be a doctor with sufficient training who would perform the surgery, even if it was not Dr Payne, seems to be an outcome of conclusion.

23. The public system depends on registrars performing surgery. There needs to be an avoidance of an undertow that persons in the public system must know that there is a fair chance that they will be operated upon by a registrar.

24. There is a tension between the need to train doctors, and the need to allow people the option to consent (and by the same token, to deny consent) to surgery performed by a particular person for whatever reason they may have, with the exception of emergency situations.

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25. It might have been a question of principle to displace the practicalities in this case in order to find that Dr Gundara did not have the consent in the sense that was necessary.

26. There is no doubt this case is a difficult one, and it has created quite a stir, not so much because of the issues that it resolves, but more so because of the issues that it *does not resolve.*

27. The genesis of most complaints is not necessarily a bad surgical outcome, but the communication, or lack thereof – in this case, it seemed to be both.

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

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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

Dell v Dalton (1991) 23 NSWLR 528

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

Legislation

Civil Liability Act 2002 (NSW)