

Case study analysis

Chair: Dr Liz Mullins – Senior Risk Consultant, Avant

Panel members

-- Dr Craig Lilienthal

-- Kerrie Chambers – HWL Ebsworth Lawyers

-- Bill Madden – Slater and Gordon

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Cases for discussion raise the following questions:

- When to disclose?
- Is there a new duty to warn?
- When is there a need to respond?

Case 1

During a colonoscopy, the bowel is inadvertently perforated by the treating gastroenterologist.

A general surgeon is called and an open repair is commenced.

The surgeon asks the anaesthetist to give IV antibiotics. He gives the patient an IV dose of a broad spectrum penicillin and metronidazole.

To his horror, the anaesthetist then notices the red sticker on the patient's notes stating that the patient was allergic to penicillin. No adverse reaction occurs.

It would appear that the patient is not allergic to penicillin.

Is the anaesthetist obliged to tell the patient of his error?

After completing the repair the general surgeon realises that this is the 5th time the gastroenterologist has called him in to repair a bowel perforation.

The surgeon calls his medical indemnity company for advice – should he report his physician colleague to the medical board in 2009?

What will be the likely situation after national registration is in place?

Case 2

G (the first plaintiff) consulted with the Defendant Dr Downs in late 2001 for the purpose of undergoing tubal ligation surgery, to obtain permanent contraception.

A laparoscopic tubal ligation was performed in early 2002 involving the application of Hulka clips to the fallopian tubes

The tubal ligation surgery did not permanently sterilise G; she became pregnant a few months after the surgery and gave birth to her fifth child in early 2003.

The claim made by G and her de facto partner D was one of type generally known as 'wrongful birth', including a claim for damages for the cost of raising the child.

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Issue

Although negligence in the performance of the procedure was initially pleaded, that was not pressed at the trial.

The issue for consideration became the plaintiffs' allegation of negligence in failing to adequately warn regarding the risk that the tubal ligation procedure may not succeed in permanently sterilising her, and thus expose her to becoming pregnant again.

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In her evidence, she said that the Defendant told her "*...that there is a risk, a 2000:1 percentage that I could fall pregnant*".

Dr Down, having no specific recollection of the preoperative consultation, gave evidence of his usual practice and by reference to his records.

His evidence was that he would discuss the risk that the surgery may fail and the patient becoming pregnant.

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The experts called by the parties expressed somewhat differing views as to the extent to which personal and generic rates of failure ought be detailed to patient not inquisitive about such matters.

The court of course recognised that whilst the opinions of expert medical practitioners regarding acceptable medical practice is a guide, in considering the standard of care, the ultimate decision regarding the appropriate standard of care is for the court pursuant to the principles in *Rogers v Whitaker* (1992) 175 CLR 479 at 490.

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...in my opinion, the Defendant failed to meet the standard required of him in that he did not make it clear that the numerical ratio of 1 in 2000 related to his experience...

...Using the standard of an ordinary skilled gynaecologist, such a practitioner would have made it clear. In my view, where the gynaecologist's personal experience is conveyed in numerical terms, it is important that it be made clear to the patient that it refers the gynaecologist's failure rate. The personal experience of the gynaecologist would be of great significance to the patient...

...I am also of the opinion that where the numerical ratio of the gynaecologist's personal failure rate is conveyed, either in response to questioning by the patient or being volunteered by the gynaecologist, then in order to provide a proper balance for the patient, the literature failure rate should be conveyed. The picture would not be complete otherwise....

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Despite the court finding that Dr Down had breached his duty as above, on the question of causation the claim failed as G was unable to persuade the court that she would have declined the sterilisation even if told that the risk was 1/500 rather than 1/2000

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Issues for discussion

- Is this likely to occur in other cases?
- Requirement of doctors to have their own data to share?
- OK for surgeons what about physicians / psychiatrists?
- What is a 'reasonable' amount of data?
- When do we run the risk of overloading patients with data?

Case 3

A wealthy and tertiary-educated couple have planned this pregnancy and have been managed by an independent midwife throughout. The woman has a GP but has not seen her since the pregnancy was diagnosed.

The birth is to take place in a outer metropolitan setting. Severe pain ensues and the woman is demanding some additional analgesia to which has been offered and previously agreed.

The partner calls the local private hospital and asks to speak to the obstetrician on call. No one is on call as such. When asked why, he explains the situation. The switchboard operator feels sorry for the man and puts the call through to an obstetrician who has just left the hospital.

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- What is the obligation on the doctor to take the call?
- What is the obligation to assess the woman?
- What is the obligation to admit and treat the woman?

In the meantime, the woman starts to bleed profusely and lapse into a poor conscious state and progress of the baby has stalled.

- Is the responsibility of the doctor any different now?