Normative causation and inherent risk in the medical negligence context

Paul v Cooke [2013] NSWCA 311

By Anna Walsh[1]

It is common for practitioners in medical negligence cases to become focused on proving a breach of duty of care and to overlook the need to prove causation. Considering the link between the breach of duty of care and the harm suffered by the plaintiff is vital to the success of a case for a plaintiff, with several recent appellate level decisions confirming that causation is becoming an area of legal dispute.[2]

While it seems trite to state that a doctor owes a duty of care to their patient, the scope of that duty may not always be clear and can be the subject of a legal claim. In the recent New South Wales Court of Appeal decision of *Paul v Cooke*,[3] the Court was asked to consider the scope of a radiologist's duty of care in circumstances where he had admitted a failure to report properly on the appellant's CT angiogram, which would have diagnosed an aneurysm of the right cerebral artery, and then to consider its connection to the harm suffered by the appellant. Additionally, the Court reviewed the two-staged test for proving causation in s5D(1) of the *Civil Liability Act* 2002 (NSW) and the application of s5I of the Act. These sections state that there is no liability in negligence for harm suffered by another person as a result of the materialisation of an inherent risk, with an inherent risk being defined as something occurring that cannot be avoided by the exercise of reasonable care and skill.

Although the facts in this case are very specific and not contested, the causation aspect of the case is complex. In 2003, the time when it was agreed that the respondent ought to have diagnosed the aneurysm, expert evidence established that treatment of aneurysm would have been either by traditional surgical clipping or a newer technique of endovascular coiling. The appellant lost the opportunity for treatment at that time, by either technique, because the aneurysm was not diagnosed. When the aneurysm was eventually diagnosed in 2006, she sought advice from her doctors who recommended treatment by endovascular coiling. Unfortunately, during the procedure, and most probably as a result of the technique used, the aneurysm ruptured and the appellant suffered a stroke.

Key areas of agreement between the expert neurosurgeons included the following:

- The aneurysm had not grown in the two-and-a-half-years between 2003 and 2006.
- The appellant would have undergone surgical clipping if she had the opportunity in 2003.
- The risk of rupture of aneurysm during clipping in either 2003 or 2006 was 5-10 per cent, as against the risk of rupture during coiling in either 2003 or 2006 of 1-2 per cent.
- However, if there was a rupture during clipping, the risk of causing injuries was 5 per cent as compared to a 50 per cent risk of rupture during coiling causing injuries.
- If the appellant had undergone the clipping procedure in 2003, the probability that she would have avoided rupture and stroke was greater than 99 per cent.

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The appellant sued the respondent for negligence, alleging that he had a duty to exercise reasonable care and skill in the reporting of the CT angiogram; that his failure properly to do so was negligent; and that had the aneurysm been diagnosed in 2003, she would have undergone surgical clipping of the aneurysm and would not have suffered a stroke. Although the respondent admitted that he failed to properly report on the CT angiogram in 2003, he denied that his duty extended to taking care to avoid the occasioning of the harm suffered by the appellant. In the alternative, the respondent pleaded s5I of the Act as a defence: that at all times between 2003 and 2006, the risk of intra-operative rupture of endovascular coiling was the same. He denied that his failure to exercise reasonable care and skill in reporting on the CT angiogram caused the materialisation of that inherent risk.

On the facts and the expert evidence, the appellant was successful in proving *factual causation*. This involved a hypothetical consideration of the outcome for the appellant in 2003 on the assumption that the respondent accurately diagnosed the aneurysm. However, in regards to the *scope of liability*, there was much challenge. Section 5D(1)(b) of the *Civil Liability Act* 2002 (NSW) requires the courts to normatively evaluate the appropriateness of holding the defendant responsible for the plaintiff's harm. The appellant's case failed on this ground at first instance, with Brereton J stating that the rupture of the appellant's aneurysm was logically unassociated with the respondent's failure to diagnose and that the appellant met the requirement for factual causation only in the 'barest sense'.

Brereton J commented on the type of risk and the type of case and how this impacted upon his Honour's conclusion regarding the scope of liability under s5D(1)(b) of the Act. In respect to risks, his Honour noted that the intra-operative rupture of the aneurysm through the endovascular coiling procedure was not linked to the respondent's failure to diagnose the aneurysm on the CT angiogram in 2003 because there was no increase in the risk of rupture (a foreseeable result if the aneurysm increased in size) as a result of the delay in diagnosis between 2003 and 2006. This failure to demonstrate any deterioration in condition between 2003 and 2006 nullified the relationship between diagnosis and harm and was fatal to the appellant's case.

Regarding the *type of case*, his Honour distinguished between failure to diagnose and failure to warn, noting that the reasons for requiring a health practitioner to exercise care and skill in providing information to a patient is to protect a patient from harm from inherent material risks that are unacceptable to the patient. On the other hand, the rationale for the duty to diagnose is to enable appropriate treatment to be identified to protect the patient from harm from a progressive condition.

As this was a failure to diagnose case, his Honour found that the purpose of the respondent's duty was limited and did not include enabling the appellant to make an informed choice in relation to the treatment she may undertake, when she would undergo that treatment, and who should perform it. Submissions were made by the appellant at first instance regarding the importance of timely and accurate diagnosis of serious conditions by radiologists as relevant public policy concerns to impose liability on the defendant. His Honour dismissed these arguments on the basis that they were invitations to disregard the requirements to establish causation.

Quite obviously, the factual matrix of this case is similar to that of the seminal High Court case of *Chappel v Hart*,[4] except that *Chappel* was a failure to warn case. The underpinning successful causation argument in *Chappel* was that the complications associated with the surgery in question would not have arisen if the surgery had been performed on a different occasion. The expert evidence in this case supported the 'different occasion' theory. Brereton J specifically differentiated failure to warn and failure to diagnose cases, with his Honour noting that it is only appropriate to extend the scope of liability based on this 'different occasion' argument in failure to warn cases because the relevant risk in these cases gave rise to the duty to warn.

Regarding this scope of the respondent's duty of care, Brereton J held that it did not extend to responsibility for the outcome of the endovascular coiling procedure two-and-a-half years after the respondent's failure to report on the CT angiogram. In reaching this conclusion, his Honour found that 'scope of duty' considerations are relevant to breach of duty and, therefore, the respondent was able to escape liability, despite admitting that he failed to exercise due care and skill in reporting on the CT angiogram.

The Court of Appeal comprised Basten, Ward and Leeming JJ. In a 3:0 decision, the appeal was dismissed. There was a reiteration of the trial judge's reasoning and conclusions regarding s5D(1) of the Act, which are summarised as follows:

- The delay in diagnosis had no meaningful causal relationship to the harm suffered by the appellant. The point of s5D(1)(b) is to impose a further, separate, necessary condition before there can be a finding of causation.
- It was no part of the respondent's duty to avoid the risk of intra-operative rupture in a later

procedure.

- Failure to warn cases are distinguishable from failure to diagnose cases. The latter turn on whether a risk has materialised by reason of the delay and the evidence in the present case was that the appellant's condition did not worsen between 2003 and 2006.

Basten J noted that although s5D(1)(b) of the Act is designed to ensure that courts distinguish between factual causation and policy considerations, there is no rigid dichotomy between factual causation and scope of liability so that factors establishing factual causation are to be disregarded when considering policy issues identifying the scope of the respondent's liability. In a similar vein, Leeming J found that it would be most surprising if scope of liability, which is central to establishing the limits of negligence, was confined purely to normative considerations. His Honour went on to note that there is no basis in the statute, or any decision on it, to support the notion that the strength of the causal connection is irrelevant to the determination of what is appropriate.

Of interest, though, are comments regarding the application of s5I in a medical negligence context. The respondent pleaded that the injury was an inherent risk of the coiling procedure which he did not perform and accordingly no liability could be attributed to him. The appellant argued that s5I had no application in this case because the relevant risk had to be attached to the alleged negligent act or omission of the defendant, not a third party.

At first instance, Brereton J concluded that s5I was a codification of the common law and therefore could not be used as a defence. Additionally, Brereton J stated that the 'reasonable care and skill' referred to in s5I is that of the defendant and not a subsequent intervener, whose intervention was necessitated by the defendant's negligence. On appeal, however, Leeming J found that once it is established that a particular harm is a result of the materialisation of an inherent risk, there is no liability for the harm under Part 1A of the Act. Additionally, His Honour held that the application of s5I is not restricted to the defendant.

As it stands, the practical tips to take away from this decision are many. It is important for medical negligence practitioners to consider whether the case is one of diagnosis or warning, as the court may take different approaches when considering causation based on the type of case. Inherent risk can be raised as a defence in a diagnosis case and is not limited to the conduct of the defendant. This highlights the need to ensure that there is adequate evidence from the plaintiff to prove that a lack of due care and skill was the cause of the harm. The 'different occasion' argument for causation may be used only in arguing the scope of liability aspect of causation in warning cases, although it may be possible to frame a case as both a failure to warn and a failure to diagnose. ■

A special leave application to the High Court was heard on 14 February 2014 and was not granted.

Notes: **1** Anna Walsh was the solicitor for Mrs Paul. **2** See, for example, *Wallace v Kam* [2013] HCA 19; *King v Western Sydney Local Health Network* [2013] NSWCA 162; and *Paul v Cooke* [2013] NSWCA 311. In all of these cases, the plaintiff was unsuccessful. **3** [2013] NSWCA 311. **4** (1998) 195 CLR 232.

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