NSW STATE LEGAL CONFERENCE
SESSION 36 – HEALTH LAW
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A. Overview

This paper outlines issues to be examined from a dental/legal aspect in a 20 minute presentation as a part of the Health Law Session which aims to provide insight into health law from the perspectives of lawyers who were formerly health professionals.

This outline is drafted mindful that the topic is extensive and it is prepared with a view to stimulating thought and promoting discussion rather than providing a definitive discourse on dentistry and the law.

Lawyers are cautioned to rely on their own research and inquiries in advising clients as this paper does not purport to be definitive on the matter examined. Lawyers will also be mindful of the evolving nature of the law and the importance of the facts in individual matters.

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B. Introduction

1. Professional practice, be it as a dentist or as a lawyer, has at its heart the idea of assisting others to solve problems arising in areas which the practitioner has gained specialised knowledge through association with and education by colleagues.

2. Devising solutions, founded on professional study and experience, to either patients' or clients' problems, is thus at the heart of professional practice.

3. It is trite to say that before a solution can be conceived the problem must be identified.

4. Practitioners in all professions face the challenge of an increasingly rights orientated society with reduced acknowledgement of individual's obligations or the broader community interests.

5. This has seen an increase in disputes due to patient or client dissatisfaction which has manifested in a rise in professional negligence claims/litigation. Indirect costs to the community include the increased price of indemnity insurance.

6. This also creates an "us against them" mentality, often fostered by popular press cries of "elitism", which necessarily

leads to defensive professional practice at a cost to the whole community.

7. There is much to commend the culture of preventive professional practice and preventive treatment modalities which are common in dental practice and equally applicable to those professionals practising in law.

8. Both professions have seen the recent passage of new legislation aiming to regulate professional conduct[1].

9. Yet, at its heart, professions and professionals in practice are bound by ethical considerations which they share with their colleagues.

10. It has also been noted that at times a professional's general duty to the community may at times over-ride the professional's obligations to his or her client[2].

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[1] See *Dental Practice Act, 2001*; *Legal Profession Act, 2004.*
[2] *Prestia v Aknar* (1996) 40 NSWLR 165 at 184.

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C. Communication

11. The process of diagnosis or identification of a problem has at its heart effective communication between professional and patient or client.

12. The adage "listen to the patient, she is providing your diagnosis" remains both timeless and apt.

13. Effective communication also ensures that both the professional and the patient or client have a similar expectation as to the destination to which both are travelling.

14. Dental practice and dental litigation share a number of common features particularly in regard to communication.

15. Recent trends in the practice of dentistry including increasing patient demands for "cosmetic dentistry" continue. The importance of the ability to ensure that effective communication is achieved between practitioner and patient is clear.

16. In the March 2006 edition of the NSW Dentist, Dr Roger Dennett, Peer Advisor stated:

> *"In the world of cosmetic dentistry, patient expectations are high and there is a need for practitioners to have excellent communication skills as well as excellent clinical skills."*

17. Discord between practitioner and patient often has its genesis in the patient's belief (usually with the benefit of hindsight) that the practitioner failed to sufficiently inform of treatment choices and modalities.

18. A failure to resolve such discord usually results in proceedings in the nature of a professional negligence claim being commenced.

19. The challenge to the busy professional is how to record accurately and for future use what happened and what was said, to defend such claims.

20. A professional negligence claim without an allegation of failure to warn is a rare beast in the year 2006. Nonetheless, restrictions such as those introduced by the *Civil Liability Act, 2002* present some challenges to such claims.

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D. Facts

21. Contemporaneous histories and a record of discussions with patients provide the most objective and probative evidence as to what occurred during the course of treatment.

22. The adage "no notes, no defence" abides.

23. Furthermore, forensic assistance is available in this area by effectively providing for preliminary discovery such as Practice Note SC CL 7 Professional Negligence List, which includes:

> *16. It should be noted that indemnity costs may be awarded in respect of work necessitated by an unreasonable failure to provide access to or copies of medical or hospital records <u>before</u> or after commencement of proceedings.*

24. Dental practitioners aim to establish expectations, outcomes and an agreed understanding by the following means:

- A detailed history and an accurate record of prior events, desired outcomes and matters discussed prior to action.
- Clarity as to pricing and time cost.
- Limitations to outcomes.
- Treatment options including referral.

25. Such matters are equally applicable to lawyers taking instructions from either plaintiffs or defendants in a potential dental negligence claim, and also for the legal relationship.

26. Early and detailed instructions by way of a written statement from a plaintiff including conversations in admissible form can be seen as maximising potential outcomes.

27. The potential for a Court to make directions under UCPR r 31.4 that a party to furnish a witness statement is becoming, and will become more prevalent, mindful of the overriding purpose: CPA, s 56.

28. Furthermore, such a statement allows a practitioner to confidently set out assumptions in correspondence seeking expert assistance per UCPR, Part 31, Division 2.

29. The importance of the facts or assumptions upon which an expert opinion is founded is notorious, and well described in the authorities.

30. The same issues and protocol are equally applicable to a defendant to a dental negligence claim.

31. Diligent effort in the early stages on such matters may be seen as preventive practice to ensure that there is not a need to recast proceedings at a later stage.

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32. Given that reliance is a crucial ingredient in claims of failure to warn, the need to recast a case to fit with new facts or documents may often be fatal to the prospects of both a plaintiff or a defendant.

33. Ultimately professional negligence claims have at their heart the conflict between the patient's individual rights and appropriate expectation that services will be rendered to the proper standard being that of the ordinary reasonable professional[3], as opposed to the need of the community to foster the availability of professional care for the entire community.

34. A current debate in the dental profession is the disparity between the availability of dental services per head of population in rural New South Wales as opposed to urban areas.

35. Matters of policy necessarily intrude into this balancing exercise.

36. One of the key aspects of responsibility at law is causation or how things came about.

37. The common law test of causation being a matter of fact to be determined by common sense and experience[4].

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[3] *Rogers v Whitaker* (1992) 175 CLR 479.
[4] *March v Stramare (E & MH) Pty Ltd* (1991) 171 CLR 506.

38. A claim of professional negligence in regard to dental treatment which was ultimately determined by the High Court of Australia in 2000 remains a leading case and essential reading in this area of jurisprudence.

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D. Causation

39. *Rosenberg v Percival*[5] is a decision of the High Court of Australia delivered on 24 October 2000, in a failure to warn case brought against a dental surgeon by a patient. In health law and in the subspecies relating to dental jurisprudence, this case is mandatory reading for lawyers. It provides insight into potential pitfalls and problems in regard to dental claims.

40. The plaintiff was Dr Percival, an experienced nurse, who was suffering from a dental condition known as a temporo-mandibular joint disorder and her dental condition was worsening.

41. The plaintiff sought advice and ultimately treatment from Dr Rosenberg, a dental surgeon, who performed the operation to remediate her disorder without negligence. Regrettably the plaintiff suffered a rare but severe and permanent disabling form of TMJ disorder of which the surgeon was unaware.

42. In the trial at first instance, the plaintiff claimed damages for breach of duty by Dr Rosenberg including for failing to warn of the risk of the complication from which she suffered.

43. At first instance the trial judge found that there was no breach of duty and also in any event <u>that if there had been</u>

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[5] (2001) 205 CLR 434.

a breach of duty it was not causally related to the patient's injuries, because if the patient had been aware of the risk she would have proceeded with the operation contrary to her evidence which the trial judge rejected.

44. On appeal from a decision of the Full Court of the Supreme Court of Western Australia (which reversed the trial judge's findings on the first matter and ordered a retrial on the causation issue) the High Court held:

> *"The trial judge's finding that if the patient's had been drawn to the particular risk she would not have gone ahead with the surgery was properly open and did not disclose an appellable error. Hence the failure to warn of the risk of the complication was not proved to have been legally causative of the injury".*

45. Salient paragraphs from the reasons for decision include:

Per Gleeson CJ at [17]:

> *17. The trial judge's findings on the issue of causation did not depend solely upon the adverse opinion he formed as to the respondent's credibility, although that was important. He also took into account the seriousness of her need for corrective surgery, her evident willingness to undergo the risks of a general anaesthetic, with which she was familiar by reason of her professional background, her failure to ask specific questions about risk, and the fact that the possibility of which, on her case, she should have been warned, was "very slight". The conclusion that the respondent had not established that, if her attention had been drawn to the risk in question, she would not have gone ahead with the surgery, was justified by the evidence and supported by cogent reasons. It should not have been overturned by the Full Court.*

Per McHugh J at [27]:

> 27. *When the tribunal of fact has rejected the patient's evidence that he or she would not have proceeded with the surgery, however, the ordinary restrictions on appellate review of fact finding apply. If the tribunal of fact is a judge, as in the present case, an appellate court must respect the advantage that the judge has had over the appellate court in seeing and hearing the patient give evidence. Ordinarily, the appellate court cannot reverse the finding of the judge unless it is satisfied "that any advantage enjoyed by the trial judge by reason of having seen and heard the witnesses, could not be sufficient to explain or justify the trial judge's conclusion". Unless that condition is satisfied or the judge has misdirected himself or herself or has misapprehended the evidence or has indicated that the demeanour of the patient played no part in the finding, the appellate court cannot reverse it. These restrictions on appellate review also apply when the trial judge makes a positive finding that the patient would have undertaken the procedure if warned of the relevant risks.*

Per Gummow J at [80]:

> 80. *The phrase "likely to attach significance to" as it appears in both limbs does not present a threshold issue of the same nature as that presented by the issue of causation. In the authorities, reference has been made to "information that is relevant to a decision or course of action" and "matters which might influence the [decision]". It is not necessary when determining materiality of risk to establish that the patient, reasonable or otherwise, would not have had the treatment had he or she been warned of the risk in question. The test is somewhat lower than that. However, it is necessary that the reasonable patient or particular patient respectively would have been likely seriously to consider and weigh up the risk before reaching a decision on*

whether to proceed with the treatment. The authorities referred to above should be read in that way.

E. Legislation

38. In New South Wales the passage of the *Civil Liability Act, 2002,* introduced after *Rosenberg v Percival*, included s.5 D which is most relevant in regard to failure to warn claims.

> *(3) If it is relevant to the determination of factual causation to determine what the person who suffered harm would have done if the negligent person had not been negligent:*
>
> *(a) The matter is to be determined subjectively in the light of all relevant circumstances, subject to paragraph (b), and*
>
> *(b) Any statement made by the person after suffering the harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest.*

46. Other important provisions include s 5 O, Standard of Care for Professionals, which modifies the common law test as to professional negligence found in *Rogers v Whitaker* to introduce the concept of "peer professional opinion". However, such modification does not apply to the duty of a professional to warn of a risk, per s.5 P.

Division 6 Professional negligence

5O Standard of care for professionals

> *(1) A person practising a profession (**a professional**) does not incur a liability in negligence arising from the provision of a professional service if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice.*

(2) However, peer professional opinion cannot be relied on for the purposes of this section if the court considers that the opinion is irrational.

(3) The fact that there are differing peer professional opinions widely accepted in Australia concerning a matter does not prevent any one or more (or all) of those opinions being relied on for the purposes of this section.

(4) Peer professional opinion does not have to be universally accepted to be considered widely accepted.

5P Division does not apply to duty to warn of risk

This Division does not apply to liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in respect of the risk of death of or injury to a person associated with the provision by a professional of a professional service.

47. A likely but unintended consequence of this dichotomy is that more claims will be framed to fall under s.5 P which necessarily involves a different standard.

48. The requirements of **Uniform Civil Procedure Rules 2005** also raise useful considerations for dental jurisprudence:

31.27 Service of experts' reports in professional negligence claims

(cf SCR Part 14C, rules 1 and 6; DCR Part 28, rule 9B)

(1) Unless the court orders otherwise, a person commencing a professional negligence claim (other than a claim against a legal practitioner) must file and serve, with the statement of claim commencing the professional negligence claim, an expert's report that includes an opinion supporting:

(a) the breach of duty of care, or contractual obligation, alleged against each person sued for professional negligence, and

(b) the general nature and extent of damage alleged (including death, injury or other loss or harm and prognosis, as the case may require), and

(c) the causal relationship alleged between such breach of duty or obligation and the damage alleged.

(2) In the case of a professional negligence claim against a legal practitioner, the court may order the plaintiff to file and serve an expert's report or experts' reports supporting the claim.

(3) If a party fails to comply with subrule (1) or (2), the court may by order made on the application of a party or of its own motion dismiss the whole or any part of the proceedings, as may be appropriate.

(4) In this rule:

professional negligence *means the breach of a duty of care or of a contractual obligation in the performance of professional work or in the provision of professional services by a medical practitioner, an allied health professional (such as dentist, chemist, physiotherapist), a hospital, a solicitor or a barrister.*

professional negligence claim *means a claim in the court for damages, indemnity or contribution based on an assertion of professional negligence.*

F. Potential reform

49. The *Civil Liability Act* contains Part 5 – Liability of public and other authorities. Provisions in that part include a statutory expression of the common law concerning resources, responsibilities etc of public or other authorities.

50. Accepting that the community has a significant interest in fostering and encouraging the availability of professional services from a dedicated number of citizens bound by altruistic and ethical motivation, the time may well be approaching where legislative reform such as that in Part 5 is required to address the exposure of professionals.

51. Such reform may well come at the price of re-regulation and pulling back from Chicago School market theory in regard to professional practice.

52. This necessarily raises the conundrum of whether like oil and water, professional practice and profit motive will not mix.

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