

SUPREME COURT OF QUEENSLAND

CITATION: *McDonald v Ludwig & Anor* [2007] QSC 028

PARTIES: **DONNA McDONALD**
(plaintiff)
v
DR DIRK G LUDWIG
(first defendant)
STATE OF QUEENSLAND
(second defendant)

FILE NO: S289 of 2003

DIVISION: Trial Division

PROCEEDING: Trial

ORIGINATING COURT: Supreme Court at Brisbane

DELIVERED ON: 31 January 2007

DELIVERED AT: Brisbane

HEARING DATE: 7, 8 and 12 December 2006

JUDGE: Muir J

ORDER: **That the plaintiff's claim be dismissed**

CATCHWORDS: TORTS – NEGLIGENCE – ESSENTIALS OF ACTION FOR NEGLIGENCE – DUTY OF CARE – SPECIAL RELATIONSHIPS AND DUTIES – PROFESSIONAL PERSONS – where plaintiff was first defendant's patient – where plaintiff underwent operation for sterilisation – where first defendant performed operation by placing filshie clips on plaintiff's fallopian tubes – where first defendant removed adhesions – where plaintiff's bowel perforated – whether the first defendant was in breach of the practitioner's duty of care – whether any loss or damage suffered in consequence

TORTS – TRESPASS – TRESPASS TO THE PERSON – ACTION FOR DAMAGES – OTHER MATTERS – where plaintiff was first defendant's patient – where plaintiff underwent operation for sterilisation – where first defendant performed operation by placing filshie clips on plaintiff's fallopian tubes – where first defendant removed adhesions – where plaintiff's bowel perforated – whether plaintiff gave consent for first defendant to remove adhesions for a dual purpose or for a purpose other than sterilisation

Chatterton v Gerson [1981] QB 432, applied
Healing (Sales) Pty Ltd v Inglis Electric Pty Ltd (1968) 121
 CLR 584, cited
Karabotsos v Plastex Industries Pty Ltd [1981] VR 675, cited
Lorca v Holts' Corrosion Control Pty Ltd [1981] Qd R 261,
 cited
Murray v McMurchy [1949] 2 DLR 442, cited
Rogers v Whitaker (1992) 175 CLR 479, cited
*Secretary, Department of Health and Community Services v
 J W B & S M B* (1992) 175 CLR 218, cited

COUNSEL: A M Daubney SC, with him M J Drysdale, for the plaintiff
 JA McDougall for the defendants

SOLICITORS: Herbert Geer & Rundle Lawyers for the plaintiff
 Tress Cox for the defendants

Introduction

- [1] The plaintiff was born on 14 November 1964. On 9 February 2000 she was a public patient at the Hervey Bay hospital when the first defendant performed a laparoscopic sterilisation on her. During the procedure, the first defendant, using laparoscopic scissors, dissected an adhesion which he detected between the small bowel and interior abdominal wall. The plaintiff suffered a perforation of the small bowel, either in the course, or as a result, of this procedure, as the plaintiff contends, or spontaneously in consequence of her condition of Crohn's disease, as the defendants contend. As a result of the perforation, the plaintiff suffered great pain, distress and inconvenience. She underwent a number of operations concluding with an ileostomy in about July 2001. Since then she has used a bag or appliance fitted to the stoma created in that operation.

The substance of the plaintiff's case

- [2] It is alleged that during the performance of the adhesiolysis, the first defendant perforated the plaintiff's small bowel and failed to detect the perforation.
- [3] The first defendant is alleged to have failed to exercise due care, skill, diligence and caution in performing the surgery and to have performed the adhesiolysis which:
- (a) was not a necessary surgical procedure;
 - (b) was not a surgical procedure for which the plaintiff's informed consent had been obtained;
 - (c) due to the presence of Crohn's Disease, carried an increased risk of trauma to and perforation of the small bowel; and
 - (d) was neither an appropriate nor suitable nor indicated surgical procedure.
- [4] It is further alleged that:
- (a) the first defendant failed to provide the plaintiff with any adequate advice or warnings as to the risks and potential complications associated with the adhesiolysis; and

- (b) that the adhesiolysis constituted assault and battery on the person of the plaintiff, being performed without the plaintiff's informed consent.

- [5] The second defendant as the operator and controller of the hospital and the employer of the first defendant is alleged to be liable for his conduct.

The defendants' case

- [6] The defendants admit that, in consequence of dividing the adhesions in order to properly identify the right fallopian tube, the first defendant may have caused damage to the small bowel which, at about 11 pm on the day of the operation, caused it to perforate. Alternatively, it is alleged that the small bowel may have perforated spontaneously at about that time as a consequence of and in the presence of Crohn's disease.
- [7] It is admitted that the first defendant did not identify the perforation at the time of surgery but that it was identified by the first defendant on 11 February 2000 when he performed surgery to repair the perforation.
- [8] The defendants allege or admit that:
- The perforation was at the site of the adhesions divided by the first defendant;
 - The adhesiolysis was a necessary surgical procedure performed as part of the sterilisation procedure so as to facilitate the identification and visualisation of the plaintiff's anatomy and, in particular, the entire fallopian tube so as to confirm the accurate application of the Filshie clip;
 - The adhesiolysis was consented to by the plaintiff in her consent to the performance of the laparoscopic sterilisation;
 - The plaintiff's Crohn's disease increased the risk of complications in the laparoscopic sterilisation about which the plaintiff was warned prior to her giving consent to that procedure;
 - The first defendant provided the plaintiff with adequate advice and warnings.

Dr Stitz's report of 14 June 2005

- [9] Dr Stitz, Colorectal Surgeon, was the sole expert witness called on behalf of the plaintiff on the issue of liability. He was the consultant in charge of the plaintiff's case at the time of her operation on 25 July 2001 for the repair of an abdominal fistula. Referring to the operation by Dr Ludwig on 9 February 2000, Dr Stitz said in a report dated 14 June 2005:

“If the surgeon had any doubt that the structure was not the Fallopian tube, then it would have been entirely appropriate to dissect the fimbrial end [of the left fallopian tube] away from the bowel adhesions so that identification was 100% accurate. Even though Dr Ludwig appeared to be confident initially, he may well subsequently have felt that he could not have been 100% sure without some dissection of the adhesions to the tube.

Therefore, one cannot argue with such a cautious approach designed to ensure Ms McDonald's successful sterilisation procedure.

Dr Ludwig decided to perform more extensive adhesiolysis. His technique of using laparoscopic scissors without diathermy was correct using the abdominal wall peritoneum as a guide to the dissection. He was not aware of any problems at the time. Laparoscopic dissection of adhesions in this manner is well documented and the risk of bowel damage is related to the density of the adhesions. He did not comment particularly that they were difficult to divide so I would assume that he was satisfied that the adhesions were able to be divided laparoscopically rather than needing a laparotomy or open surgical approach.”

- [10] Dr Stitz concluded, however, that it was not “the correct approach” to divide the adhesions in the absence of any evidence of small bowel obstruction. He stated:
 “If the patient had had no evidence of obstruction before the operation and at the time of operation, adhesiolysis was not indicated as there is no evidence that this prevents future problems with obstruction.
 Further, the division of adhesions is always followed by further adhesion formation, usually within a few days.”
- [11] In Dr Stitz’s opinion, dividing adhesions always carries a small risk of traumatising the small bowel and that risk is increased where there is “active Crohn’s disease”. He said:
 “More importantly, healing is compromised in Crohn’s disease particularly if the patient is on an immune modulator such as 6 Mercaptopurine.”
- [12] He concluded that:
 “... in the presence of Crohn’s disease, [he] would have been less likely to divide adhesions around the small bowel unless ... specifically addressing the Crohn’s disease surgically after failed medical treatment.”
- [13] Whilst making no criticism of the first defendant’s division of adhesions for the purpose of ensuring that he had correctly identified the right fallopian tube, Dr Stitz criticises the first defendant for the extent of the surgery stating in that regard:
 “The site of the perforation was higher in the abdominal cavity (in the region of the previous anastomosis) so I would conclude that the traumatised bowel was unlikely to be related to the small intestine attached to the fimbrial end of the tube.”
- [14] Dr Stitz described Crohn’s disease as:
 “... an inflammatory disease of the gastrointestinal tract and can occur throughout the gastrointestinal system. However, the most common site is the terminal ileum just before it enters the large bowel in the right lower abdomen.”
- [15] But in his opinion, “...there did not seem to be obvious active Crohn’s disease [to the extent of significant inflammation around the bowel]. [Accordingly] ...freeing the adhesions to the tube would seem appropriate ...”
- [16] The plaintiff’s perforation occurred after the adhesiolysis but there was no doubt “that it was related to unrecognised trauma at the time of the adhesiolysis.”

[17] Dr Stitz stated:

“The small intestine can be traumatised even with good technique and usually, is not a problem provided the trauma is recognised at the time and repaired. Occasionally, as in this case, the potential weakness is tiny and difficult to recognise. There is no evidence that poor technique per se was the primary problem in this case.”

Dr Stitz’s report of 7 December 2006

[18] In a report of 7 December 2006, Dr Stitz observed:

“In the operation note on the 09/02/2000, it is recorded that adhesions to the anterior abdominal wall were ‘separated to 80%’. In my opinion the only reason for needing to divide these adhesions would have been to gain access to the pelvis but the operation record suggests that both tubes could be seen clearly right from the beginning, raising the question whether adhesions in the right iliac fossa (right lower abdomen) could have been left untouched particularly as the operative approach was from the left side.”

Dr Stitz’s oral evidence

[19] In his evidence-in-chief, Dr Stitz referred to an operation the plaintiff had undergone in 1991 in which her large bowel was resected and the small bowel was joined to the large bowel in the ascending colon. It was this earlier operation which created the adhesions which the first defendant felt the need to remove in his operation of 9 February 2000. Dr Stitz explained that “adhesions are scar tissue bands” which form as part of the healing process. Because of its mobility the small bowel often “becomes attached to the area of any operation.” When that happens, a kink in the bowel may form and cause a blockage. The mere presence of adhesions though is “normal” and needs to be dealt with only in case of a blockage or where the adhesions obscure the anatomy preventing or hindering a surgical procedure.

[20] The defendant’s case was put to Dr Stitz in these terms:

“...what confronted [the first defendant] when he looked at the screen was a clear view of the left fallopian tube, a restricted view of the right fallopian tube, but he was able to identify the tube by manipulation of the uterus using the spackmann. He then, for certainty, divided the adhesions ... that were interfering with his line of vision to the fimbriae to the extent of 80 per cent which was sufficient to allow him to identify the fimbriae, then he was satisfied that he’d found the right structure. Now, if that evidence is accepted, could I suggest to you that you would have no criticism of [the first defendant]?”

[21] Dr Stitz responded:

“...the left-hand side of the abdominal cavity was completely clear of adhesions and another option would have been to transfer the camera into the lower abdomen and also put the operating ports lower in the abdomen where he could in fact have seen the pelvis quite clearly.”

[22] The following exchange then occurred:

“His Honour: That, I take it, in your view, would have obviated the risk of causing any damage to the bowel? – Correct. I mean, the problem here is that [the] small bowel was damaged as part of the dissection.

Mr McDougall: That is an inherent risk in the division of adhesions? – Absolutely. I think, and you will see in my report, that I believe from the information that I had, that that was explained to the patient as well, that there was an inherent risk ... with dividing adhesions, particularly in somebody that has had previous bowel surgery... we should avoid dividing adhesions whenever possible for the simple reason that adhesions reform almost immediately within the first 48 hours, so the only reason for dividing the adhesions was, in fact, to get access. Any extensive [divisions] would have been inappropriate, particularly, I might add, in a patient with Crohn’s disease.”

- [23] Dr Stitz ruled out the possibility that the plaintiff had suffered a spontaneous rupture of the bowel as a result of her Crohn’s disease condition. His conclusion in that regard was “... because the findings in the pathology specimen were not so florid and involving the full thickness of the bowel wall to suggest that it was an imminent stage of perforating...” He added, “I think it was a traumatic perforation” which took effect at about 11 o’clock on the evening of the operation when the plaintiff suffered a bout of very severe pain.
- [24] It was put to him that the damage to the bowel could have occurred in “the very first cutting of the adhesion.” He responded:
 “Yes, indeed. The damage to the bowel wall could have been at the beginning of the 80 per cent, or at the end of the 80 per cent ... It may not have been a complete incision into the bowel at that time. It may have just been weakened and subsequently it perforated. ... The actual sequence of events is no fault of Dr Ludwig as far as the actual bowel itself. It is well documented that dividing adhesions can result in trauma to the bowel and provided the patient is told that then that is perfectly reasonable, so I don’t see any problem with that part of it at all.”
- [25] In response to a query from me concerning the expectation that a surgeon would take care to avoid making a division perceived by him to be “unduly creating a risk of perforation of the bowel,” he responded:
 “It was at the risk of repeating myself that I didn’t actually say that. I can repeat two things really; one is that I don’t believe adhesions should have been divided any more than they had to, and I think that’s an argument the Court will have to decide. The second is that I am convinced that there were other ways of getting better visualisation of the pelvis which didn’t occur, so notwithstanding those statements if you start dividing adhesions then there is a risk of traumatising the small bowel.”
- [26] In the course of re-examination, Dr Stitz said:
 “...lastly in this particular patient with Crohn’s disease one has to be extremely careful about dissecting around the bowel because there is always the risk that if the bowel is damaged, that it will, in fact, be

more likely to form – to get infections, not heal and, in fact, as happened here, a fistular form.”

Professor Jones’ evidence

- [27] The principal expert witness called on behalf of the defendants on the issue of liability was Professor Jones, consultant obstetrician and gynaecologist. In a very brief report dated 5 May 2004, he said:
- “Her previous surgery would have increased her risk of having intra-abdominal adhesions that could obscure obtaining a clear view into the pelvis.
- The operation notes record that the placement of the Filshie clips and the area of adhesiolysis were checked (for position and damage) before the completion of the surgery. These actions indicated to me that due care and attention had been paid during the operation.
- I am of the strong opinion that the freeing of the adhesions that obscured the fimbrial end of the right Fallopian tube was mandatory to ensure that this structure had been occluded by the Filshie clip. Failure to do so could have resulted in an unplanned pregnancy.
- The postoperative management provided was of a high standard and the diagnosis of small bowel perforation was made much quicker than I have seen on other occasions.”
- [28] In his opinion dividing adhesions in order to “visualise the fallopian tube” was not unusual. He was referred to the first defendant’s description of “one large curtain like structure of adhesions and multiple adhesions” and to the first defendant’s statement that he divided approximately 80 per cent of the adhesions. Asked to express his view on that matter, he said:
- “[The first defendant] has been very cautious to divide only what he needed to see as opposed to trying to restore the abdomen to a pristine state.”
- [29] In the course of the discussion Professor Jones said that:
- “During the division of adhesions by [the first defendant], there could have been an inadvertent puncture. This does not necessarily mean that he was negligent or, that he was not exercising care. These things can happen and that is why you warn of them.”
- [30] Professor Jones gave the opinion that it was “absolutely necessary” for the first defendant to identify the right fallopian tube. He added that, faced with the same problem, he may well have divided the adhesions.
- [31] Asked if the first defendant could have attempted to gain access to the right fallopian tube by another means, he said that this was “a matter entirely for his judgment” and that it was “not possible to be critical of the judgments he made.”
- [32] In cross-examination Professor Jones agreed that the only reason for dividing the adhesions could be to enable the right fallopian tube to be identified. Asked what would have been lost by moving the camera to another location, Professor Jones responded:
- “He wouldn’t have lost anything. It was worth a try. Whether he would have succeeded, that’s the point.”

- [33] In re-examination Dr Jones said that the average distance between the end of the caecum and the right ovary was one to two centimetres.

The first defendant's account of his consultation on 7 December 1999

- [34] The first defendant has been a Fellow of the Australian and New Zealand College of Obstetrics and Gynaecologists since 1996. He received his initial medical training in Germany and came to Australia in 1992. He was the Acting Director of Obstetrics and Gynaecology at the Hervey Bay Hospital and had undertaken about 200 laparoscopic sterilisations when he discussed with the plaintiff her proposed tubal ligation procedure on 7 December 1999. In the course of that consultation, the first defendant explained to the plaintiff: that the procedure should be regarded as non-reversible; that there was a one in 100 risk of the procedure failing to prevent a pregnancy; how and where the Filshie clips were to be applied and alternatives to the procedure, such as the use of an inter-uterine device.

- [35] The first defendant made a written record on the back of the consent form signed by the plaintiff of matters discussed with her.

- [36] The notes include:

“Risks of injury to bowel
bladder
major vessel
Open tummy/laparotomy to fix
If unable to gain access to tubes laparotomy requested
Notify all abnormalities after operation. (major operation might be necessary).”

- [37] He asked the plaintiff whether she had had any previous procedures and was told that she had had a bowel resection some years earlier and that she suffered from Crohn's disease.

- [38] He told her that “... adhesions are commonly encountered after previous bowel surgery or any surgery, and that this could complicate and even make access to the abdomen impossible”. The plaintiff's response was a request to have a laparotomy done if necessary to complete the tubal ligation. He has a clear recollection of speaking to the plaintiff about “her Crohn's disease and the increased risk of bowel complications with that.”

- [39] On the day of the consultation the first defendant recorded in clinical notes:
“She knows that she is at an increased risk of bowel injury and has accepted that. Wishes to go ahead (with) laparotomy if unable to gain access to one tube.”

- [40] A little above that entry appears “NAD? adhesions right side...”

The first defendant's account of the procedure

- [41] On 9 February 2000 the first defendant inserted a spackmann's device through the plaintiff's cervix into her uterus. He then inserted a 7 mm port in the left upper quadrant of her abdomen to hold a trocar, a hollow instrument through which a telescope or other device may be inserted. After checking with a telescope to ensure that the trocar was in the correct place, he inflated the abdominal cavity with carbon

dioxide gas. The plaintiff was then put into a head down position so that the small bowel fell away from the pelvis and did not restrict access to the uterus. The first defendant then:

“... saw a curtain of small bowel adherent to the right lower abdominal wall or right iliac fossa ... It was from the midline to the pelvic side wall – to the right side of the abdomen. ... It was basically one broad adhesion ... like thin scar tissue of greyish matter ... two or three centimetres thick ... where tissue is glued to the abdominal wall ... [the adhesion was] about 2 centimetres [from the brim of the pelvis].”

- [42] The first defendant elevated and manipulated the uterus with the spackmann’s device. By this time he had inserted the Filshie Clip applicator into the abdominal cavity through another port. He was able to identify the left and right fallopian tubes and applied the clips. He was not able to see the fimbriae of the right fallopian tube, however, because the telescope was too short to extend past the adhesion.
- [43] Although he was certain of his identification of the fallopian tubes before applying the clips, the published criteria for the subject procedure required the practitioner to “visualise and define the complete tube in its entirety ... until the fimbriae.” To this end the first defendant tried, unsuccessfully, to push the adhesion away with the telescope. He then “separated the adhesions as close as possible ... to the abdominal wall, and as far away as possible from the ... small bowel” separating “as much adhesion as was necessary to be able to visualise the tube.” The adhesion was about 10 centimetres in length. He used the word “adhesions” generically to encompass “one curtain-like adhesion.” Asked how much of it he divided, he responded:
 “Well, I thought it was 80 per cent, but it may have been 60 per cent of that, just sufficient enough to be able to visualise the tube.”
- [44] The first defendant considered the separation necessary to enable him to sight the peripheral part of the right fallopian tube and he was concerned also to obviate future bowel problems.
- [45] He conceded that the plaintiff did not consent to his “undertaking a separation of adhesions to protect her from future bowel problems...”

Findings as to the warnings imparted by the first defendant to the plaintiff from 7 December 1999

- [46] Although the back of the consent form signed on 7 December makes no express reference to Crohn’s disease, the previous bowel operation or adhesions, I find that the first defendant advised the plaintiff to the effect that her Crohn’s disease and previous operation placed her at increased risk of bowel injury and that adhesions resulting from previous surgery might make access to her fallopian tubes difficult or impossible.
- [47] The entries on the back of the consent form are a mixture of cryptic notes and subject headings. They do not purport to provide the substance of the advice given by the first defendant to the plaintiff in the course of a consultation which lasted approximately 30 minutes. It is implicit in the first defendant’s notes made after the consultation that he had satisfied himself that the plaintiff understood that she was at increased risk of bowel injury. Both that note and the back of the form make it apparent that difficulty of access to the fallopian tubes was also a matter of

discussion. The note, by referring to “increased risk”, supports the conclusion that the discussion encompassed the consequences of a pre-existing condition or pre-existing conditions. The first defendant was an experienced surgeon and there is no reason to doubt that on 7 December 1999 he was of the belief that there may well have been adhesions resulting from the plaintiff’s earlier operation which could impede access to the fallopian tubes. He claims that he discussed this with the plaintiff and I find it probable that he did so. The consultation was unhurried and the first defendant gave every appearance of being careful and deliberate in his conduct. The probabilities are that obvious matters relating to risk and complications were raised.

- [48] The plaintiff recalls informing the first defendant of her Crohn’s disease but gave no evidence of informing him of her 1991 operation. I think it unlikely that the earlier operation was not mentioned by her.

Findings on the purpose and extent to which the adhesions were divided

- [49] I gained the distinct impression from the first defendant’s oral evidence that he was concerned to minimise the extent to which he had divided the adhesions and to portray such work as limited to that necessary to permit the ulterior end of the right fallopian tube to be sighted. The operation report completed by the first defendant on 9 February after the operation is inconsistent with his oral evidence. The report relevantly states:

“OPERATION PERFORMED

Lap[aroscopic], separation of adhesions

DETAILS OF OPERATION (including FINDINGS, PROCEDURES, CLOSURE)

9/02/2000

Laparoscopy

EUA: Ut a/v, And clear

Bladder emptied

Spackmann’s applied

- skin incision LUQ and direct insertion of 7mm trocar;
- insufflation under direct vision;

Double puncture technique; 7mm & 8 mm, later changed to 5mm;

- picture: good

situs:

- Uterus: normal
- Right tube: easily identifiable, fimbriae pulled behind adhaesions (sic) and not visible.
- Right ovary: normal
- Left tube: and Left ovary normal as well as POD and Peritoneum;

There are adhaesions (sic) in the RIF ~~in the LLQ and right side~~ of small bowel to ant abdo wall; those could be separated to 80% (sharp, no bleeding). Identification of tubes and application of one Filshie clip to each of them. No other problems encountered.”

- [50] The part of the note under the heading “OPERATION PERFORMED” suggests that, at the time he compiled his report, the first defendant regarded the separation of adhesions as more than merely part of the laparoscopy. The later part of the note which refers to adhesions is consistent with this view. Its wording is more in

accordance with a description of a procedure in which adhesions were separated to the greatest extent possible rather than one concerning separation to the smallest extent necessary to provide visual access.

[51] In cross-examination the first defendant admitted that “the separation of the adhesions was something over and above the procedure [he was] in there to perform.”

[52] On 9 June 2000 the first defendant wrote to the plaintiff’s general practitioner in response to a query from him advising:

“Donna was admitted on 09.02.2000 for day surgery and a laparoscopic sterilisation was done. There were RIF adhesions secondary to her previous bowel operation because of Crohn’s disease. Application of both clips was possible but I could not see the peripheral end of the right tube. Because of concern for future bowel problems, and to visualise the peripheral part of the right tube I proceeded to separate the adhesions.”

[53] Referring to the surgery performed by him on 11 February 2000, the first defendant wrote:

“... I did a laparotomy and found a small bowel perforation which I oversewed in the area of the previous adhesiolysis.”

The letter offers strong support for the conclusion that the first defendant had a dual purpose in dividing the adhesion.

[54] In evidence-in-chief the first defendant also admitted that a reason, “but ... not the main reason”, for dividing the adhesion was to assist in avoiding “bowel obstruction”. I accept the first defendant’s evidence that this purpose was a subsidiary one. But the existence of this dual purpose makes it unlikely that the first defendant would have been concerned to confine the division to that necessary to enable him to see the whole of the right fallopian tube. The operation report and letter point in the same direction as does the concession referred to in paragraph [51]. For the above reasons I find it probable that the adhesion was divided by the first defendant to a greater extent than was necessary to enable him to sight the fimbriae of the right fallopian tube. Although I do not regard the first defendant as an untruthful witness, I do consider that, as one would expect, he has only a limited recollection of the 9 February procedure. I am of the view also that some of his evidence is based on reconstruction with the benefit of hindsight.

The plaintiff’s arguments on liability

[55] The first defendant was negligent in that he:

- (a) Separated more adhesions than were required in order to enable him to visualise the right fallopian tube;
- (b) Separated adhesions in an area away from the subject operation site when no consent had been obtained for such a procedure; or
- (c) If the first defendant’s “current version” is accepted, failed to re-locate or to manoeuvre the trocar port to a position that enabled the identification of the right fimbriae without the need for separation of the adhesions in the area of the right abdominal wall.

- [56] Each of the above conclusions is supported by the evidence of Dr Stitz. Professor Jones also conceded that it would have been “worth a try” for the first defendant to have relocated the camera.
- [57] The consent given by the plaintiff for the surgery, which negates a claim for trespass to the person, is limited to the performance of the surgery for which consent is given. In *Murray v McMurchy*¹ the plaintiff consented to a caesarean section delivery. During the performance of the procedure, the surgeon noted a number of uterine fibroids which could be a hazard in a later pregnancy and performed a tubal ligation. It was held to be without the patient’s consent.

Consideration of the expert evidence

- [58] Dr Stitz’s criticisms of the first defendant’s treatment of the adhesions is based largely on his construction of the first defendant’s report of the 9 February operation and on his understanding that the perforation of the small bowel was at a point “adherent to the previous anastomosis² between the small bowel and the ascending colon.” That point, on Dr Stitz’s estimation, was approximately 10-12 cms away from the fallopian tubes.
- [59] Dr Stitz initially inferred from the report that the whole of the right fallopian tube could be seen. If that were not the case, his view was that the division of the “adhesions” near the fimbriae could not have been the division of adhesions to 80 per cent noted in the first defendant’s report, having regard to the distance between the perforation and the ovary. The first defendant gave evidence that he did not intend to convey by the relevant part of the report that the whole of the right fallopian tube was visible and I accept his evidence in this regard. The report in fact states expressly, in respect of the right fallopian tube, “fimbriae pulled behind adhesions and not visible.”
- [60] The description “fimbriae pulled behind adhesions” was taken by Dr Stitz to mean that there were adhesions to the fimbriae. The first defendant said that this was not so. He explained that his use of the word “pulled” was erroneous and arose, in part, out of a language problem: German being his first language. I think it probable that the first defendant’s explanation of his linguistic error in this regard was arrived at with the benefit of more than a little hindsight. I find, however, that he did not intend to convey by his report that the adhesions were attached to the fimbriae. Even unaided by the first defendant’s explanation, it is not clear that the words of the report convey that what is pulling the fimbriae behind the adhesions is the adhesions themselves.
- [61] Although the first defendant’s command of the English language is good, it is far from perfect. His report was prepared after what appeared to him to be a routine operation. It is not altogether surprising that the notes are cryptic in nature and lack the amplification which would more clearly have identified precisely what was done in relation to the adhesion and why.
- [62] In my view, whether the first defendant’s explanation of the location and nature of the adhesion should be accepted depends to a considerable extent on whether the location of the perforation of the small bowel is so far removed from the likely site

¹ [1949] 2 DLR 442.

² A joint between two segments of bowel.

of the separation of the adhesion as to make the first defendant's explanation implausible.

[63] In cross-examination Dr Stitz said:

"...If there were adhesions between the caecum and the anterior abdominal wall, there would have been absolutely no reason to divide them because there would have been easy access to the pelvis, because there's plenty of other room in the abdominal cavity."

[64] At a later point in cross-examination Dr Stitz remarked:

"... but the anterior abdominal wall is no where near the tube. The tube is in the pelvis. The anterior abdominal wall is out of the pelvis. So it is not appropriate to say that adhesions to the anterior abdominal wall are in the same area as the adhesions around the fimbriae. ...
The only way you can get pulled behind anything is by adhesions. That's what pulls it anywhere, otherwise the fimbriae are quite mobile."

Dr Stitz placed the site of the plaintiff's 1991 anastomosis at least 10 centimetres from the end of the plaintiff's caecum.

[65] Curiously, and rather unsatisfactorily, the first defendant, who gave evidence after Dr Stitz, did not comment on what he gauged to be the distance between the plaintiff's caecum and her right ovary.

[66] The evidence relied on by the defendants to falsify Dr Stitz's opinion of the location of the caecum was that of Dr Howe, the surgeon who had operated on the plaintiff in 1991.

[67] Dr Howe stated that the site of the 1991 anastomosis effected by him was approximately 5 centimetres from the top of the caecum. He was in the best position to know the location of his procedure and, not surprisingly, his evidence in this regard was not challenged.

[68] In cross-examination Dr Stitz accepted that in a person of normal and average anatomy the caecum is positioned about 1 to 5 centimetres from the right ovary. It was put to him that if the first defendant observed that the caecum was about 3 centimetres from the right ovary he could not disagree. He responded in the affirmative. He accepted also that normally "the terminal ileum joins the caecum near its base", i.e. at a distance of approximately two to three centimetres. He accepted also that the small bowel can be tethered in a particular position because of adhesions.

[69] In commenting on the report, Dr Stitz conceded it to be "possible that the small bowel was adherent down there [the location of adhesions at about the fimbrial end of the fallopian tube]. Dr Stitz continued:

"...it is possible that he couldn't see, but my interpretation of the operation note is that it clearly states that he could visualise both tubes and ovaries and that there were fimbrial adhesions, there is no expansion on whether those fimbrial adhesions were anywhere near the bowel, and in the operation note there is quite documented evidence that the small bowel was adherent to the anterior abdominal

wall in the right lower abdominal wall, what he calls the right iliac fossa, which is down on the right.”

[70] Asked “If his Honour were to accept [the first defendant] as being a truthful witness and that was [the first defendant’s evidence that the first defendant’s vision was obscured by the adhesion and he had to divide 80 per cent of it to see the fimbriae of the right fallopian tube] then you would have no criticism of his procedure, would you”, he replied:

“It’s absolutely true. If [the first defendant] said there were small bowel adhesions to the fimbrial end of the tube and that they weren’t to the anterior abdominal wall and they weren’t the adhesions that were divided, then I would certainly accept that, but that’s not what is said in the operation note.”

[71] At another point of the cross-examination Dr Stitz said that he would have no criticism of the first defendant’s actions “if in fact the anterior abdominal wall adhesions were actually preventing his access to the pelvis ...”

[72] It is plain from this and other parts of Dr Stitz’s evidence that if there was one curtain-like adhesion divided in only one location in order to permit the fimbriae of the right fallopian tube to be viewed, then with one significant exception, Dr Stitz would have no criticism of the first defendant’s procedures.

[73] Dr Jones saw nothing to criticise in the way in which the first defendant had conducted the procedure, including the separation of the adhesion.

[74] Support for the conclusion that there may have been more than one adhesion and that the first defendant cut adhesions in more than one place can be obtained from his use of the plural “adhesions” and from the emphasis in the report on the separation of adhesions. But the first defendant professes a distinct recollection of there being the one curtain-like structure and of the manner in which it was divided. Despite my scepticism about the extent of the first defendant’s recollection and concern that hindsight has played a role in the recollection he now professes, I consider it probable that he does recall the nature and location of the adhesion he encountered. The subject operation was routine and one amongst many, but events occurred shortly after it which are likely to have focussed his mind and helped prevent matters of central significance to the operation being lost from his recollection. I accept the first defendant’s evidence that there was one large adhesion which was divided for dual purposes.

[75] The exception referred to in paragraph [72] above is the question of whether there was a breach of duty by the first defendant in not attempting to avoid the necessity of dividing the adhesions by inserting the telescope through another port or ports. A difficulty faced by the plaintiff in relation to this question is that Dr Stitz’s initial opinion, expressed in his report of 14 June 2005, was that it was reasonable to divide adhesions in the region of the fallopian tube in order to enable proper anatomical identification. Dr Jones was of that opinion and the evidence is that the course taken by the first defendant accords with current gynaecological practice.

Conclusions on the negligence issue

[76] The standard of care owed by a doctor to his or her patient is that of “the ordinary skilled person exercising and professing to have that special skill ... that standard is

not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade.”³ And whether a medical practitioner has fulfilled his duty of care cannot be answered merely by ascertaining whether his conduct accords with “... the practice followed ... by a responsible body of opinion”.⁴ But the following of such a practice will provide cogent evidence that the subject conduct was not in breach of the practitioner’s duty of care.⁵

[77] In electing to divide the adhesion in order to sight the right fallopian tube and in not first moving the port for the telescope to another location the first defendant was acting in accordance with the normal practice of gynaecologists performing laparoscopic sterilisations. Dr Jones, an eminent gynaecologist, considered that the first defendant had exercised due care and skill.

[78] The first defendant explained why, in the circumstances encountered by him, it would have been impractical and non-productive for him to reposition the telescope.⁶ I accept his evidence in that regard. No doubt was cast on it by skilful cross-examination. Furthermore, the evidence does not disclose that, on the balance of probabilities, the repositioning of the telescope would have obviated the need for dividing the adhesion. Consequently, even if there had been a breach of duty in not repositioning the telescope before resorting to dividing the adhesion, it has not been shown that any loss or damage was suffered in consequence. For the above reasons, the plaintiff has failed to prove negligence.

Trespass to the person

[79] Battery is defined in these terms in *45 Halsbury’s Laws of England*:⁷
 “A battery is an act of the defendant which directly and either intentionally or negligently causes some physical contact with the person of the plaintiff without the plaintiff’s consent.”

An action in battery lies without proof of damage.⁸

[80] McHugh JA observed in *Secretary, Department of Health and Community Services v JWB & S MB*:⁹
 “At common law, therefore, every surgical procedure is an assault unless it is authorised, justified or excused by law.”

A patient’s consent to the procedure may provide such authorisation.

[81] In that regard, in the joint judgment in *Rogers v Whitaker* it was said:¹⁰
 “Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only found an action in negligence and not in trespass; the consent necessary to negative the offence of battery is

³ *Rogers v Whitaker* (1992) 175 CLR 479 at 487.

⁴ *Ibid.*

⁵ Cf *Rogers v Whitaker* at 489.

⁶ Transcript 143 and 169.

⁷ 4th ed para 1311.

⁸ *Ibid.*, para 1316.

⁹ (1992) 175 CLR 218 at 310.

¹⁰ at [15]

satisfied by the patient being advised in broad terms of the nature of the procedure to be performed ...”

- [82] Reference was made in the joint judgment to *Chatterton v Gerson*¹¹ in which Bristow J relevantly observed:¹²

“In my judgment what the court has to do in each case is to look at all the circumstances and say, ‘Was there a real consent?’ I think justice requires that in order to vitiate the reality of consent there must be a greater failure of communication between doctor and patient than that involved in a breach of duty if the claim is based on negligence. When the claim is based on negligence the plaintiff must prove not only the breach of duty to inform but that had the duty not been broken she would not have chosen to have the operation. Where the claim is based on trespass to the person, once it is shown that the consent is unreal, then what the plaintiff would have decided if she had been given the information which would have prevented vitiation of the reality of her consent is irrelevant.

In my judgment once the patient is informed in broad terms of the nature of the procedure which is intended, and gives her consent, that consent is real, and the cause of the action on which to base a claim for failure to go into risks and implications is negligence, not trespass.”

- [83] Although the plaintiff may not have been expressly informed that it may become necessary to divide adhesions, she was told of their possible presence and was made aware that they could cause difficulties and increase the risk of failure and of injury to the bowel. It was implicit in what was said that the first defendant may need to deal with them in some way or other. How they were to be dealt with was not a matter of concern to the plaintiff. She made it plain that if the laparoscopic procedure could not be carried out she wished to undergo more radical surgery to ensure her sterilisation.

- [84] Having regard to the whole of the discussion between the plaintiff and the first defendant on 7 December 1999, and applying the broad test propounded in *Chatterton v Gerson*, I conclude that the plaintiff implicitly consented to the division of adhesions for the purposes of facilitating the laparoscopic sterilisation and for any purpose incidental thereto.

- [85] But did the implied consent cover division of the adhesion for a dual purpose and to a degree greater than was necessary to enable the fimbriae of the right fallopian tube to be viewed?

- [86] It is recognised that consent is not necessary for an emergency surgical procedure if the patient lacks capacity to consent.¹³ There is no suggestion here though that the division of the adhesions to a greater extent than was necessary for the purposes of sterilisation resulted from an emergency. The first defendant in acting as he did was seeking to advance the plaintiff’s interests but that is beside the point. The subject division of the adhesion for the purposes of preventing a bowel obstruction served no useful purpose (once the adhesion had been divided sufficiently to permit the

¹¹ [1981] QB 432.

¹² At 442-443.

¹³ *Secretary, Department of Health and Community Services v J W B & S M B* (supra) at 310.

fimbriae of the right fallopian tube to be observed) and was contrary to sound surgical practice. But those considerations, whilst possibly relevant, are not determinative of the question of consent.

- [87] Where the alleged wrongful conduct consists of the continuation of a surgical procedure commenced within the scope of a consent, absence of consent may be difficult to establish. That is particularly so where, as is the case here, the point at which the surgical procedure ceased to be within the scope of the consent cannot be ascertained. In such cases, it will often be possible to regard the whole of the surgery as within the scope of the intended procedure, broadly viewed. And the fact that the surgeon cut, excised or divided more than was consistent with sound surgical practice or reasonable for the purposes of the intended procedure, will not, without more, render his acts non-consensual.
- [88] In my view, the implicit consent to the division of adhesions for a specific purpose did not operate as a consent to perform the same or similar acts for a different and unrelated purpose. But any division of the adhesion to permit full identification of the right fallopian tube was not removed from the scope of the consent because of the existence of another purpose for the division. By analogy, some support for this conclusion may be obtained from the discussion of trespass to land in *Healing (Sales) Pty Ltd v Inglis Electric Pty Ltd*.¹⁴
- [89] The evidence does not establish that in dividing the adhesion there was a point at which the first defendant ceased to have a dual purpose and continued the division with the sole purpose of avoiding a bowel obstruction. The contrary was not suggested to him in cross-examination.
- [90] Consequently, I find that the first defendant did not commit the tort of trespass on the person of the plaintiff. Even if the tort had been committed, the plaintiff did not establish that the first defendant's conduct caused any loss or damage.
- [91] I accept the evidence of Dr Stitz to the effect that it was not possible to tell when, in the course of the division of the adhesion, the injury to the bowel was sustained. It is thus impossible to conclude on the balance of probabilities that the plaintiff's injury was suffered during or as a result of a procedure for which consent was lacking.

Damages

- [92] Despite the above, it is desirable that I make findings in respect of damages in case the plaintiff successfully appeals.

The plaintiff's employment history

- [93] The plaintiff left school after year 11. She was then aged 16. Since that time she has had a considerable number of jobs, mainly as a cook/kitchen hand. She has no formal qualifications as a chef. The plaintiff first obtained employment after her injury as a console operator and then as a cook and console operator. She earned \$17 an hour in the course of a 32-hour week and her employment in this regard lasted about seven months. She was then employed as a hotel cook at \$16.71 an hour before tax. Her hours of work varied between 27 hours for a three-day week to

¹⁴ (1968) 121 CLR 584 at 498, 599 per Barwick CJ and Menzies J and at 506 per Kitto J.

working full-time five to six days a week. She carried out the normal duties of an assistant chef. In explaining why she left that employment, she said:

“It was becoming too much, they expected you to work seven days a week, put more and more pressure on, you needed to do more and more work.”

- [94] The plaintiff’s present employment is as a shop assistant with a hot bread bakery in Howard which sells other food lines such as salads, sandwiches and pies. The plaintiff’s gross salary is \$600 for a 24-hour week. She finds it too tiring to work longer hours. Her employer, who gave evidence, said that the plaintiff was “good but slow [and] has frequent breaks”. He said that he was interested in offering the plaintiff a management position but is worried about putting too much pressure on her. In a management position the plaintiff would be paid as much as \$900 gross for a full “five, six days.” If the plaintiff worked a full five day week in her present role, she would earn around \$700 per week and up to \$900 if she worked Saturday and Sunday.
- [95] Dr O’Loughlin, surgeon and Director of Surgery at the Royal Brisbane Hospital, in a report dated 9 September 2003, expressed the opinion that the presence of a stoma would not preclude a person from pursuing a career as a chef or “from obtaining or holding down useful employment”. In cross-examination Dr O’Loughlin reaffirmed his opinion that there was generally no impediment to a person in the position of the plaintiff carrying on the normal range of activities associated with the plaintiff’s type of employment.
- [96] Dr Schneider, a specialist in occupational medicine, made a report dated 26 November 2003 in which he gave the opinion that the plaintiff “may well be capable of returning to full time employment within the next 6 months.” Dr Schneider considered that there was likely to be some discrimination from prospective employers concerning the plaintiff’s working in a kitchen because of “largely unfounded hygiene concerns.” He thought also that the plaintiff would require “a very understanding employer” if to be employed “in a large resort-type kitchen” or similar.
- [97] The evidence does not suggest that the plaintiff has experienced any particular difficulty in obtaining employment of the type she was engaged in prior to her injury. Nor does the expert medical evidence suggest that the plaintiff’s condition imposes any substantial physical limitation on her capacity to carry out such work. If the plaintiff worked a full five day week she could earn between \$700 and \$900 per week. Her principal reason for opting for the shorter working week is tiredness. The medical evidence does not link the plaintiff’s tiredness to her stoma. I accept that the plaintiff experiences some restriction in her movements through wearing the stoma. Her use of the stoma has brought about a reluctance on her part to engage in some types of physical activities. Those matters result in limiting the pace at which the plaintiff is able to work as does the necessity for her to take breaks from time to time to tend to a colostomy appliance.
- [98] The expert medical evidence is to the effect that the closure of the stoma would involve a relatively routine operation and there are no medical reasons why the closure should not take place. Dr O’Loughlin, who has performed hundreds of such operations, said he would regard the procedure as a “routine medium level” one. When asked about possible complications, he said that for the most part they were

minor and could be dealt with by simple measures. In his opinion, rejoining the bowel and closing the stoma would be relatively straightforward and “would eliminate all the problems that she is continuing, apparently, to experience”.

[99] The plaintiff was scheduled to have an operation to close the stoma in December 2001. But she declined to proceed with the operation because she was afraid of complications. She explained in her oral evidence that she was petrified of “things that could go wrong, doctors in general ... I was just scared of the doctors.”

[100] The defendants did not plead a failure to mitigate on the part of the plaintiff. Perhaps this was because the rather horrifying history of the plaintiff’s operations and suffering after her first operation on 9 December 1999 would have made it difficult to sustain a finding that her failure to have corrective surgery was unreasonable.¹⁵ It was argued on behalf of the defendants however that in assessing future loss the possibility that the plaintiff might have the stoma reversed in future ought be taken into account. Senior Counsel for the plaintiff did not contend that there was any objection in principle to the defendants’ approach but submitted that any discount should be “marginal” because the plaintiff had not overcome her “deep seated and genuine concerns” over a period of about five years and there was nothing to suggest that her attitudes were likely to change.

[101] The plaintiff struck me as a sensible practical woman who continued to experience considerable concern and disquiet about the consequences of having the colostomy apparatus. It interferes with the enjoyment of sexual relations. Occasional leakage of the apparatus when in bed, when working or when socialising causes unpleasantness and embarrassment. So too does noise which is emitted from time to time from the location of the apparatus. The plaintiff’s freedom of movement is also restricted. There is thus considerable pressure on the plaintiff, despite her fears, to have the stoma reversed. In my view, there is an appreciable chance that she will have the reversal operation and damages should be discounted accordingly.

[102] The loss of future income resulting from the plaintiff’s use of the colostomy apparatus is difficult to assess. Despite the medical evidence to which I have referred, I am satisfied that there is some limitation on the jobs available to the plaintiff within her chosen sphere of work. I accept that the restrictions on her range of movements accompanied by the necessity to service the apparatus in the course of the day make her work more tiring than would otherwise be the case. I accept also that a consequence of these matters is that it is likely that the plaintiff, although enjoying work generally, will be less inclined to work the hours she would have worked without the apparatus. Also, she will find it more difficult to work a full day doing demanding manual work for sustained periods. In my view, the likely result in the future is that the plaintiff’s hours will be reduced by about one quarter whilst she continues to wear the apparatus and her future loss will need to be calculated accordingly.

[103] The plaintiff’s counsel calculated her loss and damage as follows:

Medical expenses (admitted)	\$2,237.50
Blue Care (admitted)	\$210.00

¹⁵ Cf *Karabotsos v Plastex Industries Pty Ltd* [1981] VR 675 and *Lorca v Holts’ Corrosion Control Pty Ltd* [1981] Qd R 261.

Travel expenses (admitted)		\$2,000.00
Pharmaceutical and other expenses (admitted)		\$6,305.00
Past care (admitted)		\$10,912.00
<i>Wilson v McLeay</i> damages (admitted)		\$2,500.00
Pain, suffering and loss of amenities		\$70,000.00
Interest on past pain and suffering \$35,000.00 x 2% p.a. x 6.8 years		\$4,760.00
Past economic loss:		
\$350.00 per week for 6.8 years	\$123,760.00	
Less income earned and received	<u>\$41,169.00</u>	\$80,000.00
Interest on past economic loss \$50,000.00 x 5% p.a. x 6.8 years		\$17,000.00
Past loss of superannuation		\$7,433.00
Interest on past loss of superannuation \$9,164.00 x 5% p.a. x 6.8 years		\$2,530.00
Future economic loss \$150.0 per week for 23 years (multiplier 721.2) less 15% = \$91,953.00 rounded to		\$90,000.00
Future loss of superannuation		\$7,200.00
Future care: 2 hours per week for 45 years (multiplier 1,298) at \$15.00 per hour less 15% for contingencies		\$33,099.00
Future medical expenses		<u>\$5,653.00</u>
Total		<u>\$341,839.50</u>

[104] There was no serious challenge to the calculation of past economic loss or to the related interest calculations and I accept them. I assess pain, suffering and loss of amenities at \$70,000 and accept the plaintiff's interest calculation. That leaves future economic loss and future care for assessment. The need for future care has not been established. I assess future medical expenses at \$5,653 subject to a discount of 25 per cent. The plaintiff's claim of \$150 per week for future economic loss is reasonable. It is supported by the evidence and is in accordance with my earlier findings. It needs to be discounted, however, by 25 per cent to take into account the possibility of remedial surgery and to allow for the vicissitudes of life.

[105] I will hear submissions on costs.