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Health Insights

Phelan v Melbourne Health [2019] VSCA 205:

A reminder about the potential strength of 'usual practice' evidence

Defending or even assessing the merits of an action in medical negligence can often be challenging when the medical practitioners involved cannot recall the particular patient concerned. Through no one's fault, memory can be impeded by the lapse of time and high patient volume loads. As such, it is not unusual for defendants to rely on evidence as to their 'usual practice', together with their clinical notes, to respond to a claim in negligence - but can evidence as to 'usual practice' win the day in court? A recent decision by the Court of Appeal in Victoria provides a welcome reminder as to the potential strength of usual practice evidence, even when faced with a challenge by the plaintiff's specific recollection.

The plaintiff/applicant in this case was a young man of 34 who sustained serious fractures to the calcaneal bones in each of his ankles as a result of a fall on 21 January 2013. Relevantly, he was a smoker. He was admitted to the Royal Melbourne Hospital (the 'hospital') that same day and remained there as an inpatient until 25 January 2013, during which time he was treated conservatively and namely, without surgery. The Royal Melbourne Hospital is, and was, conducted by Melbourne Health which was the defendant/respondent in this case.

Sometime after discharge from the hospital, the applicant consulted another orthopaedic surgeon and underwent successful surgery to his left ankle. However, he has been left with ongoing pain and restriction to movement in his right ankle such that he has not been able to return to work as a plumber. [1]

Unanimous opinion of the orthopaedic surgeons who gave evidence at trial was that there is a limited timeframe within which the typical surgical treatment of a calcaneal fracture can be successfully performed, being within four weeks but at most five to six weeks of the fracture. [2]

The applicant claimed that at no time did the respondent inform him of the option of surgical treatment, and that if he had been given that advice, he would have elected to undergo an operation to his right ankle within the necessary time period, which would in turn have resulted in a better outcome in respect of his right ankle. [3] The respondent's medical practitioners "were unable to have any specific recollection of the applicant as a

[1] *Phelan v Melbourne Health* [2019] VSCA 205, paragraph 1.
[2] Ibid, paragraph 2.
[3] Ibid, paragraph 3.

patient or their treatment of him.[4]" However, by relying on clinical notes and evidence as to their usual practice, they maintained that that advice had, in fact, been given to the applicant.[5] Further, and in any event, the respondent contended that surgical treatment was inappropriate in the circumstances and would not necessarily have resulted in a better outcome for the applicant.

The plaintiff failed at trial, with the judge finding that he had not discharged "the onus of proving, on the balance of probabilities, that he was not given appropriate advice as to the option of surgical treatment while he was an inpatient at the hospital.[6]" Further, the trial judge held that even if the applicant had established that the respondent breached its duty of care, she was not satisfied that surgery would have been performed on his right ankle, nor that he would have achieved a better outcome than his current condition. [7]

The full judgement with respect to the appeal can be read [here] For the most part, it turned on a dispute as to the weight attributable to the applicant's evidence regarding his professed specific recall of events, as opposed to the respondent's evidence as to the usual practice of its medical practitioners, in combination with the clinical records. (For our purposes, we will limit this discussion to the usual practice point, save to say that each of the applicant's grounds for appeal were dismissed by the Court, including the claim that had he been adequately informed of the surgical treatment options for his right ankle, surgery would have been performed and this would have achieved a better result than the non-surgical treatment he received).

For the purposes of our discussion, it is helpful to consider the chronology of the applicant's consultations at the hospital, and examine the evidence given by both parties as to what transpired at each:

21 January 2013 – The applicant was admitted to the hospital at approximately 6.40pm. Various CT and x-ray examinations revealed the significant extent of his injuries. At 10.35pm that same evening, Dr CC, an unaccredited orthopaedic registrar who was on rotation at the hospital, attended the applicant. Dr CC gave evidence that he spent about 40 minutes with the applicant taking his history, conducting an examination and discussing his injuries with him. [8] Dr CC did not have an independent recollection of the applicant, but made a clinical note of the consultation.

Dr CC said that based on his usual practice, he would have *"explained to the applicant that there was a good reason why surgery might not be offered to him…he would have explained…that the poor condition of his soft tissues, the swelling, and his smoking habit, placed him at a very high risk of infection…that operative treatment may not lead to a better outcome.[9]"*

22 January 2013 – At 7.30am a daily orthopaedic trauma meeting was conducted at the hospital at which each new case was discussed, together with the management plan for those cases.

[4] Ibid.
[5] Ibid.
[6] Ibid, paragraph 4.
[7] Ibid, 4.
[8] Ibid, paragraph 10.
[9] Ibid, paragraph 34.

Dr CC gave evidence that although he had no recollection of the meeting, he would have presented on all the cases that he had seen the previous day, including the applicant's case, and that the decision in respect of whether surgery should be undertaken would have been made. [10]

The meeting was also attended by Mr DL, an orthopaedic surgeon, who gave evidence at the trial and said he would have been the responsible surgery consultant at the meeting. [11] He did not have an independent recollection of the applicant, but based on his review of the clinical record and "*based on his knowledge of the usual practice of the orthopaedic unit, Mr [DL] stated that the unit would have reviewed the applicant's x-rays in the meeting. Considering that the applicant was a smoker, and had swelling in both feet and a laceration on the right foot, he was recommended, at that point, for non-operative management, with a plan to reassess his presentation.[12]*"

Following the meeting, a ward round consultation was undertaken by Dr MN, who was an intern at the time. Dr MN had no recollection of the ward round, but took brief notes of it, including a note which said "reviewed x-rays. Non-operative". [13] Dr MN gave evidence that the usual practice was that the discussion from the orthopaedic trauma meeting was discussed with the patients on the ward round and that the results of that discussion were noted in the clinical record. [14]

24 January 2013 – At 8am the orthopaedic unit had its weekly 'x-ray meeting', following which a consultant ward round was also conducted. Mr DL could not recall whether he attended that ward round, but believed it was likely he did so. [15] Dr MN made a clinical note of this ward round for the applicant, which said "Progress noted. [Plan] CCmx", which he said is shorthand for "continue current management.[16]" Mr DL considered that based on that entry, *"he expected it was communicated to the applicant that surgery was still not appropriate and that non-operative management was the recommended course.[17]"*

25 January 2013 – The applicant was discharged home.

29 January 2013 & 5 February 2013 – The applicant attended the hospital's orthopaedic outpatient clinic and consulted with Dr CC and Dr YE respectively. The parties agreed that the option of surgery was not discussed at either of these appointments.

In his evidence, that applicant said that he did not recall the attendance by Dr CC on 21 January at all, and that he was heavily medicated with painkillers at the time. He said that he recalled "seeing groups of doctors on their ward rounds[18]" throughout his stay at the hospital, and that he was "told by medical practitioners to stop smoking[19]", but he believed that advice was about his general health and wellbeing. [20] He said that "the

[10] Ibid, paragraph 35.
[11] Ibid, 41.
[12] Ibid.
[13] Ibid, paragraph 38.
[14] Ibid.
[15] Ibid, paragraph 12.
[16] Ibid, paragraph 39.
[17] Ibid, paragraph 42.
[18] Ibid, paragraph 21.
[19] Ibid.
[20] Ibid.

doctors stood at the foot of his bed and said very little to him.[21]" The applicant gave evidence that he was not informed of his treatment options during the course of his stay at the hospital. [22]

On appeal, counsel for the applicant contended that the trial judge erred in failing to find that the respondent negligently failed to give the applicant adequate advice about the surgical treatment options. In support of this contention, counsel pointed to the fact that Dr CC could not recall his attendance with the applicant on 21 January, and instead relied on his usual practice.[23] The applicant, on the other hand, had provided "emphatic and specific[24]" evidence that surgical treatment had not been discussed with him.[25] Counsel contended that the trial judge erred in preferring the respondent's evidence as to "*the usual practice of its medical staff, over the specific recollections of the applicant that he was not given advice about the surgical options available to him on 22 January and 24 January 2013…the judge erred in finding that the evidence as to that matter was 'evenly balanced.'*[26]*"* Further, the clinical notes on those dates were "brief and uninformative[27]".

The Court of Appeal (the "Court") acknowledged that the medical practitioners who attended the applicant at the hospital, and at the outpatient clinic, "were unable to recall the applicant, or to have a specific recollection of the advice they gave to him.[28]" As such, they were forced to rely upon evidence as to their usual practice. Evidence as to usual practice, it said, is:

"…both admissible, and, on occasions, can be decisive…there is nothing which is intrinsic to the evidence of usual practice that necessitates a conclusion, in a particular case, that that evidence may not be preferred, or at least be given equal weight, to contrary evidence given by a witness who has, or professes to have, a specific recollection of the event in question. Plainly, the weight to be given to the evidence of usual practice, and the question whether that evidence is to be preferred, must depend upon the specific nature and quality of the evidence that is given in the particular case.[29]"

The Court referred to a number of cases in support of this principle, and particularly the case of *Connor v Blacktown District Hospital* [1971] 1 NSWLR 713 which noted the circumstances in which evidence as to usual practice may be helpful:

"In my opinion, evidence of a relevant practice may be given by a person who, on a sufficient number of occasions and over a sufficient period, has regularly and uniformly performed acts, or has observed the regular and uniform performance of acts by others, under the same circumstances and upon the same occasions, so as to make it appear probable in the minds of reasonable men that, given the same circumstances and occasions, the like acts will again be performed.[30]"

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[21] Ibid.
[22] Ibid, paragraph 57.
[23] Ibid, paragraph 63.
[24] Ibid.
[25] Ibid.
[26] Ibid, paragraph 64.
[27] Ibid, paragraph 65.
[28] Ibid, paragraph 79.
[29] Ibid, paragraphs 80 and 84.
[30] Ibid, paragraph 82, citing *Connor v Blacktown District Hospital* [1971] 1 NSWLR 713.

With respect to the applicant's initial consultation at the hospital on 21 January 2013, the trial judge found Dr CC to be a credible witness, whose evidence was convincing. The Court held that the applicant had not pointed to any aspect of that evidence which would call that finding into question. [31] Dr CC spent a lengthy period of time with the applicant on the evening of 21 January. His detailed clinical notes were reflective of both this, and the thoroughness of his consultation. Dr CC's evidence was that he would have discussed the risks of surgery in the context of the applicant's smoking habit. Given the circumstances of his consultation, the Court held that it was "quite improbable that the doctor would have been concerned with giving the applicant advice about the general ill-effects of smoking on his health[32]", and rather, that the advice was given in the context of the potential effect that smoking might have on the success of any surgical treatment. [33]

Relevant to the strength of his usual practice evidence, was the fact that Dr CC had previously seen around 10 presentations of calcaneal fractures that year, and that the orthopaedic trauma meetings had considered approximately 50 presentations that year also. This provided "a sound factual foundation for Dr [CC] to give evidence as to his usual practice, and the usual practice of the hospital, in giving advice to patients who had suffered such injuries.[34]"

By way of contrast, the Court believed the applicant's evidence lacked specificity. [35] His recollection as to the details of his admission was vague, and he acknowledged that he could only remember "bits and pieces" of what happened on 21 January 2013. [36] Although the trial judge believed him to be a credible witness, the Court held there was substantial basis for her to prefer the evidence of Dr CC. In support of this, was the fact that the hospital records noted the applicant was "alert and orientated, and that he denied having any pain in both feet" as at 10.35pm that same night, indicating that his cognitive state "was not impaired to the extent he was unable to understand advice given to him.[37]"

The Court's analysis of each party's evidence as to the content of the consultations on both 22 January and 24 January followed a similar trajectory. The applicant's evidence "rose no higher than that the respondent's medical staff at no stage discussed with him the possibility or option of surgical treatment.[38]" However, the Court considered that that was no reason for the judge to reject the evidence given by the respondent's witnesses that not only did the ward rounds take place, but that the usual practice at those rounds would have been to discuss with the patient the matters considered at the immediately preceding unit meetings, including the option of surgical treatment and proposed management plan. Taking into account the professional experience of the witnesses, the evidence as to usual practice and the clinical records (albeit brief), the Court considered that the trial judge was correct to conclude that the evidence of the applicant was no more probable or reliable, in the circumstances, than the evidence of the respondent. As such, the applicant had failed to discharge the burden of proving on the balance of probabilities that the respondent had breached its duty of care.

[31] Ibid, paragraph 86.
[32] Ibid, paragraph 88.
[33] Ibid.
[34] Ibid, paragraph 91.
[35] Ibid, paragraph 93.
[36] Ibid.
[37] Ibid, paragraph 95.
[38] Ibid, paragraph 103.

For completeness, we note that the Court believed it would have been preferable for the doctors to revisit the surgical option with the applicant at the two outpatient appointments on 29 January and 5 February, however given that it was apparent (based on the evidence) that the advice would have been no different to that conveyed to him while in hospital, the failure to do so did not constitute a breach of the respondent's duty of care. [39]

Meridian Lawyers regularly assists health practitioners to respond to patient complaints and allegations of professional negligence. This article was written by Principal Kellie Dell'Oro and Associate Anna Martin. Please contact us if you have any questions or for further information.

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[39] Ibid, paragraph 118.