Welcome to the September 2015 issue of Pulse

Welcome to the September 2015 issue of Pulse, a quarterly publication with information on topical issues and developments in Australian medical and health liability.

In this issue of Pulse, we report on recent court decisions concerning:

- patient privacy;
- ownership of eggs and sperm in assisted reproductive technology;
- disciplinary decisions involving medical practitioners; and
- causation in cerebral palsy cases.

We hope that you enjoy reading this edition of Pulse and welcome your feedback. If you have comments, queries or suggestions for topics that you would like us to cover in future editions, please contact us at pulse@landers.com.au, or speak with your Lander & Rogers’ contact (see our contact details on page 11).

Lander & Rogers’ Health Law and Litigation team

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Patient privacy: when should medical practitioners disclose a patient’s confidential information?

In *Ex and Ey*,¹ the Privacy Commissioner held that a medical practitioner breached the National Privacy Principles (NPP) by disclosing a patient’s medical information to a police officer.

This decision was determined based on the *Privacy Act 1988* (Cth) (*the Act*), prior to its reforms on 12 March 2014. The Australian Privacy Principles (APP) have now replaced the NPP (except for ACT). It seems unlikely that the Commissioner’s findings would have differed if the matter was determined in accordance with the amended Act.

**Background**

Following a neighbourhood dispute, the patient contacted his local police station. The police attended the patient’s house and reported that the patient explained his concerns in a ‘highly excited and at times paranoid fashion’. The patient also admitted to suffering Post Traumatic Stress Disorder and an anxiety disorder.

Subsequently, the Sergeant called the patient’s doctor to make enquiries regarding whether the patient was psychotic. The doctor advised that ‘it was possible but further assessment was needed’.

The patient became aware of this communication when he received documents from a freedom of information request.

**The complaint**

The patient’s allegations were that the doctor:

- improperly disclosed information contained in medical records (NPP 2.1);²
- disclosed inaccurate personal information (NPP 3.1);³ and
- failed to have adequate security safeguards to protect personal information from improper disclosure (NPP 4.1).⁴
Hot Topics

Patient privacy: when should medical practitioners disclose a patient’s confidential information? continued...

Disclosure of medical records

The NPP permits several situations when a patient’s personal information can be disclosed. These include where:

• it is reasonably necessary to lessen or prevent a serious and imminent threat to an individual’s life, health or safety, or a serious threat to public health or safety;5
• there is a suspicion of unlawful activity and disclosure would be necessary for investigation;6 or
• the disclosure is required or authorised by law.7

Disclosure is also permitted to an enforcement body, where an individual has reasonable belief that disclosure is necessary for the prevention, detection, investigation, prosecution or punishment of a criminal offence.8 However, this does not override the duty of confidentiality between a medical practitioner and an individual. Following a disclosure request, medical practitioners should balance the importance of the individual’s confidentiality with the public interest in the disclosure, and consider:9

• the seriousness of the situation - for instance, an investigation into an alleged murder would be more serious than property theft;
• the risks associated with disclosure without the individual’s consent or knowledge, balanced against the implications of non-disclosure;
• their relevant professional and ethical obligations; and
• whether the circumstances indicate a serious and imminent threat to the health, life or safety of any person.

The doctor submitted that the disclosure was made in good faith. As the police called her concerning someone with whom they were clearly having dealings, she believed there was a serious and imminent threat, and this made her assume that there was an investigation into unlawful activity.

The Commissioner found the doctor could not rely on these exceptions, and should have asked the Sergeant detailed questions as to the reasons for his request. It was found the doctor breached NPP 2.1.

Disclosure of inaccurate information

An organisation (including doctors) must take reasonable steps to ensure the personal information it collects, uses or discloses is accurate, complete and up to date.10 The Commissioner found that the doctor did not breach this requirement.

Adequate security safeguards

An organisation (including doctors) must take reasonable steps to protect the personal information it holds.11 The Commissioner found the doctor breached this principle, and noted that reasonable steps could have included questioning the police officer and ascertaining if there was a serious and imminent threat to the person or the public.

Outcome

Following the finding that the doctor had breached NPP 2.1 and 4.1, the Commissioner ordered the doctor to personally apologise to the patient and pay the patient $6,500 for the loss caused.

Practice management

Medical practitioners should take any request for disclosure of personal information very seriously. They should ask the requestor detailed questions and make adequate inquiries to ascertain that the purpose of the request falls under one of the permitted exceptions. Medical practitioners are also reminded that they must take reasonable steps to ensure the information collected, used and disclosed is accurate, complete and up to date.

Authors

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1 [2015] AICmr 23
2 Current relevant provision, APP 6
3 Current relevant provision APP 10
4 Current relevant provision APP 11
5 NPP 2.1 (e).
6 NPP 2.1 (f).
7 NPP 2.1 (g).
8 NPP 2.1 (h). Note, any disclosure must be in writing.
9 Guidelines on Privacy in the Health Sector, pages 21-22.
10 Pursuant to NPP 3.1.
11 Pursuant to NPP 4.1.
Assisted Reproductive Technology

3-Parent babies - is this the future for IVF in Australia?

In February this year, British MPs historically voted, by a majority of 254, to amend the Human Fertilisation and Embryology Act 2008 to allow mitochondrial donation.1

Should the amendment be approved by the House of Lords, it will permit IVF babies to be created using biological material from three people,2 in an effort to prevent babies being born with devastating genetic diseases.

Mitochondrial diseases in babies are caused by a mother passing defective mitochondria to her baby. The amendments will allow IVF procedures to essentially swap a fraction of the mother’s DNA and replace it with that of another female donor, whose mitochondria is not defective.

Mitochondrial donation can be performed in one of two ways, either:

1. embryo repair is performed by fertilising two eggs with sperm, creating an embryo from the intended parents and another embryo from the donor. The nuclei from the parent’s embryo and the donor’s embryo are removed and the nucleus from the parent’s embryo is added to the donor embryo (which contains healthy mitochondria) and implanted in the mother’s womb. Or;

2. egg repair involves collecting eggs from the mother with damaged mitochondria and from a donor with healthy mitochondria. The majority of the genetic material is removed from both eggs and the mother’s genetic material is inserted into the donor egg, which is then fertilised by sperm.

Advocates of mitochondrial donation argue that in circumstances where mitochondrial genes are responsible for the cell’s energy, and are not responsible for inherited traits that make us who we are (such as appearance or intelligence) it is an appropriate step to take to protect babies from genetic diseases.

Others argue that it is the first step towards the creation of ‘designer babies’ and have concerns regarding the moral and ethical question of whether sacrificing two early human lives is acceptable to produce a third.

So what do these developments mean for Australia, where it is estimated that one in 5,000 babies are born with a severely disabling form of mitochondrial disease. Under Victorian legislation, it is unlawful to perform a “treatment procedure” using sperm produced by more than one person or oocytes3 produced by more than one person, or more than one embryo that is not from the same two people.4 Similarly, at a Federal level the use of an embryo produced by somatic cell nuclear transfer (SCNT) (a variation of mitochondrial donation) is prohibited in reproduction.5 Mitochondrial transfer for research purposes is possible under current laws in Australia, provided that licensing approval is granted and that the embryo is created for no longer than 14 days.

A legislative review was conducted and completed in Australia in June 2011. The prevailing consideration which was reflected by the majority of submissions, was whether the legislation should be tightened or narrowed, rather than broadened. It was ultimately recommended that the provision in the current legislation regarding SCNT should not be amended and that the legislation should not change in relation to the use of DNA from more than two people. The review committee did not consider that techniques were sufficiently advanced to be permitted.

In favour of allowing mitochondria donation, the Australian Mitochondrial Disease Foundation has called on the Australian government to reconsider its position against the human embryo research necessary to develop mitochondrial replacement techniques.6

There are, of course, lobby groups opposed to mitochondrial donation on an ethical basis. Such groups are concerned that should legislation for mitochondrial replacement be passed in Australia, there is a high possibility that it will open the floodgates to complete manipulation of the human germline.

In the ever-shifting landscape of medical advancements, it will be interesting to see whether Britain’s progressive attitude towards mitochondrial donation will be adopted in Australia.

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1 An IVF technique involving transferring nuclear genetic material from the affected mother’s egg into a donor egg.
2 1 man and 2 women.
3 An immature ovum or egg cell.
Introduction

When a couple decide to go their separate ways, it’s not unusual for parties to change their minds about previous arrangements, particularly those regarding children. This article considers whether an egg, sperm or embryo can be the legal property of its producers in assisted reproductive technology. What happens when the couple who provides the gametes to create the embryo have different opinions about its fate? Who owns a dead person’s reproductive tissue?

Scenario 1: Sperm stored with consent prior to death

Robin v The Public Trustee for the Australian Capital Territory & Anor

This case raised the question of whether cryogenically stored semen obtained from a person at his request and prior to his death constituted property, which upon his death forms part of his estate.

The sperm had been preserved following a cancer diagnosis. The evidence indicated that there were discussions between the deceased donor and his wife about ownership of the sperm and whether it would automatically transfer to her along with the rest of his estate upon his death. However, there was no written Will addressing this issue and, after his death, the donor’s estate was administered by the Public Trustee.

The Supreme Court held that the mere fact that the semen was formerly part of a human body is not sufficient to deny that it is property. The Court adopted an approach consistent with Justice White’s in Bazley v Wesley Monash IVF Pty Ltd and held that the semen stored by the Canberra Fertility Centre was property, the ownership of which was vested in the deceased while he was alive and, upon his death, in his personal representative.

The relationship between the facility and the deceased was one of bailee and bailor because, so long as the storage fees were paid and contract for storage maintained, the facility agreed to store the semen. Further, the bailor’s personal representative maintained ownership of the semen following death and could request return of the property.

Scenario 2: Sperm taken after death

Jocelyn Edwards: Re the estate of the late Mark Edwards

This case raised the question of whether the wife was entitled to possession of her late husband’s sperm, even though the sperm was extracted post-mortem and without the husband’s express consent to the procedure while he was alive.

The wife contacted the Canberra Fertility Centre and requested that the sample semen be transferred into her name. She was told that the sperm would be disposed of under the documentation signed unless otherwise prevented by relevant legislation, guidelines or court orders.

The Supreme Court held that the mere fact that the semen was formerly part of a human body is not sufficient to deny that it is property. The Court adopted an approach consistent with Justice White’s in Bazley v Wesley Monash IVF Pty Ltd and held that the semen stored by the Canberra Fertility Centre was property, the ownership of which was vested in the deceased while he was alive and, upon his death, in his personal representative.

The relationship between the facility and the deceased was one of bailee and bailor because, so long as the storage fees were paid and contract for storage maintained, the facility agreed to store the semen. Further, the bailor’s personal representative maintained ownership of the semen following death and could request return of the property.
Ownership of eggs and sperm in assisted reproductive technology

The couple married in 2005, and by 2008, the wife had still not fallen pregnant so they discussed using assisted reproductive technology to conceive. From 2008, the husband suffered from chronic back pain and feared that he had cancer. The husband also feared that he would become infertile after receiving chemotherapy. He made his wife promise that she would still have their baby, should she become pregnant. The husband did not have cancer, but before he and his wife were able to commence the IVF treatment, he tragically died in a workplace accident.

To proceed with the IVF treatment that she and her husband planned, the wife obtained consent from the Supreme Court of NSW to retrieve sperm from her husband’s body and it was transported to a laboratory and cryopreserved pending a further decision from the Court.

Justice Hulme considered that whilst the law does not generally regard a corpse and its tissues as property, the Australian High Court decision in *Doodeward v Spence* set out the principle that:

> “when a person by lawful exercise of work or skill so dealt with a human body or part of a human body in his lawful possession that it has acquired some attributes differentiating it from a mere corpse awaiting burial, he acquires a right to retain possession of it.”

In this case, Justice Hulme held:

1. the extraction and preservation of the husband’s sperm was lawfully carried out;
2. work or skill was applied to the sperm in that it was preserved and stored;
3. the person applying the work or skill was, in truth the wife - the doctors and technicians who extracted and preserved the sperm did not do so for themselves but as the wife’s agent; and
4. no-one else in the world had any interest in the sperm.

The Court found that the wife was entitled to the possession of her late husband’s sperm. However, this did not mean that the wife would be able to use the sperm to receive IVF treatment in NSW. Given that the husband did not provide written consent for a post-mortem use of his gametes, section 23 of the Assisted Reproductive Technology Act 2007 (NSW) prevented any Assisted Reproductive Technology provider in NSW from providing IVF treatment to the wife. It is, however, possible that the wife would be able to receive IVF treatment in another jurisdiction where written consent from the deceased donor is not strictly required.

**Scenario 3: Relationship breakdown after freezing of the embryos**

At the time of freezing the embryos, the couple signed a consent form requesting the embryos be discarded in the event that the parties separated. The Court reviewed the *Human Reproductive Technology Act 1991*, which provides for the consent for storage of human embryos and its control. The Court held that since the parties have now separated and can no longer achieve the purpose for which they consented to create and use the embryos, the embryos ought to be discarded, as set out in the terms of the signed consent.

**Conclusion**

These cases all pose interesting questions concerning legal interests in bodies and their tissues. They also all highlight the importance of preparing and executing consent documents regarding pre- or post-mortem gamete removal, storage and use.

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Patel permanently precluded from practice

On 15 May 2015, the Queensland Civil and Administrative Tribunal (Tribunal) delivered its decision and reasons on disciplinary proceedings commenced against Jayant Mukundray Patel. The Tribunal decided to impose the maximum penalty, permanently precluding Dr Patel from seeking registration as a health professional.

The Tribunal’s decision concludes disciplinary proceedings commenced almost 10 years ago by the former Medical Board of Queensland (Board) and closes a dark chapter in the provision of health services in Queensland.

This article considers the elements of Dr Patel’s conduct that were sufficient to convince the Tribunal that the maximum penalty was appropriate. It also describes the pathway of the proceedings, including their conclusion after significant delay.

Background

Commencing in the mid-1980s, Dr Patel was disciplined by health regulators in the United States on several occasions, both in New York and Oregon.

On 7 September 2000, disciplinary action was taken by the Oregon Medical Board in response to Dr Patel’s admission that he had engaged in unsatisfactory professional conduct in the treatment of four patients. In 2001, as a consequence of the action taken in Oregon, the New York State Board for Professional Medical Conduct required Dr Patel to surrender his license.

In 2003, Dr Patel became the Director of Surgery at the Bundaberg Base Hospital, Queensland.

In 2005, the former Medical Board of Queensland decided to refer Dr Patel to the Tribunal for disciplinary action.

After the Board’s proceedings were commenced, Dr Patel was charged with several criminal offences. Given the necessity to ensure Dr Patel received a fair criminal trial, in 2007 the disciplinary proceedings were adjourned.

On 21 November 2013, the District Court delivered its sentencing decision on fraud charges for which Dr Patel had been convicted on a guilty plea.

The finalisation of the criminal proceedings enabled the Board to progress the disciplinary action. In addition, the Board could now rely on the conviction.

On 11 May 2015, the matter was heard by the Tribunal in Dr Patel’s absence.

The referral

In late 2005, the Board formed a reasonable belief that there was a ground to commence disciplinary action on the basis that Dr Patel had engaged in unsatisfactory professional conduct. Unsatisfactory professional conduct includes misconduct in a professional respect and conduct falling below the standard expected by the public and the practitioner’s peers.

The basis for the referral proceeded on two cases, the first being that Dr Patel had obtained his registration fraudulently by providing information and documentation that he knew to be false and/or misleading in a material particular.

The second case related to Dr Patel’s treatment of a number of patients who died after he performed surgery on them. Four of the five patients had undergone surgery performed by Dr Patel that he would have been restricted from performing in Oregon, USA and/or which was beyond his surgical skill and competence and should not have been done at the Bundaberg Base Hospital.

The fifth surgery was one that demonstrated Dr Patel’s inability to determine the correct surgical approach or approach that was in the best interests of the patient.

The hearing

On 11 May 2015, the disciplinary hearing took place before the Tribunal in Brisbane.

Dr Patel did not actively participate in the proceedings. The Tribunal decided it was appropriate to hear the matter in Dr Patel’s absence.

At the hearing, the Board submitted, and the Tribunal accepted, that Dr Patel blatantly deceived the Board to gain registration as a medical practitioner and “deliberately sought the position as head surgeon at Bundaberg and calculatedly deceived [his] way into that position”.

In relation to the treatment of patients, the Board relied upon independent surgical experts who provided evidence about the nature of treatment provided to the patients, the performance of the surgery, Dr Patel’s response to surgical complications, and the tragic consequences for the patients and their families.

The Board submitted this was a case where it would be appropriate to order the maximum sanction: an order that if Dr Patel was currently registered, his registration would be cancelled and that he not be permitted to seek registration in the future.

The Tribunal’s decision

The Tribunal wholly accepted the submissions of the Board in relation to Dr Patel’s conduct and found each of the grounds of referral were established.

In accepting the Board’s submission and permanently precluding Dr Patel from seeking registration as a health professional, the Tribunal took into account:

1. the previous disciplinary action taken against Dr Patel in Oregon and New York, including prior dishonest conduct;
2. Dr Patel’s dishonesty when seeking registration;
3. the benefit of employment derived by Dr Patel from his dishonesty;
4. the criminal conviction and the comments of Justice Martin of the District Court on sentencing in relation to the deliberate nature of the dishonesty in gaining registration and employment through fraud;
5. the findings made in relation to each of the patients treated by Dr Patel;
6. Dr Patel’s knowledge that he was not sufficiently skilled to perform the procedures he performed on four of the patients;
Disciplinary Proceedings

**Patel permanently precluded from practice** continued...

7. the clinical incompetence demonstrated by the surgical cases referred to the Tribunal;
8. the tragic consequences of Dr Patel’s clinical incompetence for each of the patients; and
9. Dr Patel’s overall unsuitability to hold registration.

The Tribunal indicated that even if the matter had proceeded solely on the allegations pertaining to fraud, it would have made the same order. However, the Deputy President said that:

“The clinical incompetence matters established by the further five grounds only serve to fortify me in that view.”

There were many other surgical cases exposed by the Board’s investigation that may have also been referred to the Tribunal. However, the Tribunal’s findings demonstrate it is not necessary to refer every available case in order to establish incompetence and unsuitability, especially where there is an additional element of dishonesty.

The Tribunal’s comments about the number of allegations necessary to bring and establish a finding of professional misconduct is especially helpful for self-funded regulators. Referring an unnecessary number of clinical cases also imposes an unnecessary burden on the practitioner.

**Criminal v disciplinary**

The criminal proceedings determined by the District Court related to whether Dr Patel had committed an offence when he obtained registration and employment. The outcome of those proceedings included a conviction on four counts of professional. In contrast, the District Court had the power impacts a practitioner’s ability to practise as a health practitioner. This issue was left to the proceedings initiated by the Board in the Tribunal. The Tribunal’s powers are limited to taking action that were not designed to address, Dr Patel’s conduct as a then registered medical practitioner. This issue was left to the proceedings initiated by the Board in the Tribunal.

The Tribunal’s powers are limited to taking action that impacts a practitioner’s ability to practise as a health professional. In contrast, the District Court had the power to punish Dr Patel for his unlawful actions.

Had the Board not finalised the disciplinary proceedings, there would have been no finding about Dr Patel’s conduct in obtaining registration and employment on the basis of false and misleading information, nor would there have been a finding about his treatment of patients at the Bundaberg Base Hospital. Without a finding on the grounds of referral, other regulatory authorities could not rely upon his conduct in Australia to restrict or preclude him practicing.

**International consequences**

In 2006, the Oregon Board of Medical Examiners made a stipulated order suspending Dr Patel’s Oregon medical license “pending the conclusion of the Australian criminal and administrative process and after all penalties/conditions imposed by that jurisdiction have been satisfied.”

By operation of that order, Dr Patel was not permitted to practise medicine in the United States until the finalisation of the Tribunal proceedings. It is anticipated the next and truly final step will be a decision by the Oregon Board about whether Dr Patel is eligible to apply for reinstatement of his registration. As at September 2015, Dr Patel’s registration remains subject to the 2006 order.

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1. Medical Board of Australia v Patel [2015] QCAT 133.
3. Health Practitioners (Disciplinary Proceedings) Act 1999, Schedule: unsatisfactory professional conduct, for a registrant, includes the following—
   (a) professional conduct that is of a lesser standard than that which might reasonably be expected of the registrant by the public or the registrant’s professional peers;
   (b) professional conduct that demonstrates incompetence, or a lack of adequate knowledge, skill, judgment or care, in the practise of the registrant’s profession;
   (c) infamous conduct in a professional respect;
   (d) misconduct in a professional respect;
   (e) conduct discreditable to the registrant’s profession;
   (f) providing a person with health services of a kind that are excessive, unnecessary or not reasonably required for the person’s wellbeing;
   (g) influencing, or attempting to influence, the conduct of another registrant in a way that may compromise patient care;
   (h) fraudulent or dishonest behaviour in the practise of the registrant’s profession;
   (i) other improper or unethical conduct.
5. Above n 1, [136].
6. Above n1, [137].
7. Criminal Code 1899 (Qld), s408C(1)(d).
8. https://techmedweb.omb.state.or.us/Client/CRLME/Public/VerificationDetails.aspx?EntityID=1458320

**Comment**

The Patel saga is a timely reminder to:

- health organisations to ensure that they have adequate checks and balances so as to confirm that practitioners hold appropriate and legitimate accreditation and registration,
- health practitioners of their professional and ethical responsibilities to protect and promote public health and safe healthcare by notifying AHPRA or a National Board of “notifiable conduct” by another practitioner in accordance with legislated mandatory reporting requirements.
Disciplinary Proceedings

Sweaty palms for doctors who fail to warn about risks

The Supreme Court of New South Wales delivers a surgeon-friendly decision for elective surgery in Morocz v Marshman [2015] NSWSC 325

Procedings were brought by the plaintiff, against a specialist cardio-thoracic surgeon who performed elective cosmetic surgery on the plaintiff to treat her abnormally sweaty palms. The plaintiff alleged the surgeon had failed to warn her adequately or at all about:

1. the risk of side-effects of her surgery or the return of her condition; and
2. alternative non-surgical treatment options.

This case provides practical guidance for doctors as to how to guard against later disagreement with patients about risk warnings, and also confirms that there is no duty on doctors to refuse cosmetic surgery where there is no medical necessity.

Quality of warnings

The Court accepted that the surgeon’s usual practice was to contrast mere nuisance sweating with more severe sweating. Further, the failure to describe the risk of additional sweating as “potentially disabling” was not a failure to refer (in appropriate terms) to the side-effects or their consequences.

The Court found that the surgeon’s purported description of the Procedure as a “cure” was sufficiently qualified by his usage of percentages (“a 98-100 per cent chance”) to have warned the plaintiff of the risk her condition would not be cured.

Further observations and conclusions

Justice Harrison dismissed the plaintiff’s claim that the surgeon should have advised of more conservative options, refused surgery or indicated a divergence of medical opinion about the Procedure. He held:

“It has never been the law that a cosmetic surgeon had a legal duty to refuse elective surgery to a patient if the surgeon’s personal view, or if the reasonable medical view, was or ought to have been that the surgery was unnecessary or unwarranted. If it were otherwise the availability of purely narcissistic cosmetic procedures would be entirely foreclosed…”

Practical guidance for medical professionals

In order to minimise factual disputes, it is strongly advisable to take detailed contemporaneous notes not only of clinical diagnosis, but also of warnings given regarding risks associated with treatment options. Here, the detail contained within the surgeon’s letter to the referring GP was critical to show that relevant warnings were given to the plaintiff.

Managing patients’ expectations with reference to percentage chance of success can be a crucial aspect of discharging the duty to warn of the risk of failure or recurrence.

“Adjectival failure” to describe the extent of a potential side-effect or consequence of treatment may not be a failure to discharge the duty to warn of these risks, but a full and frank assessment is obviously preferable where possible.

Providers of cosmetic and elective surgery are not under a duty to refuse surgery simply because surgery is unnecessary or unwarranted. However, it is obviously open to them to refuse treatment where they consider that the perceived risks outweigh the potential benefits. In this case, there was certainly no duty to refuse surgery until conservative treatment options were exhausted.

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1. The procedure involves cutting nerves so that relevant sweat glands are not activated by the patient’s overactive sympathetic nervous system
2. A slow heart rate.
Disciplinary Proceedings

Causation in cerebral palsy cases

New Australian research suggests that a significant proportion of cerebral palsy cases could be caused by genetic factors as opposed to birth trauma. While the rate of caesarean deliveries in Australia has increased significantly over the last 50 years (from 5% to 34%) there has been no change in the proportion of children affected by cerebral palsy. Researchers from the University of Adelaide’s Robinson Research Institute analysed the DNA of 183 children with cerebral palsy (and, where possible, their parents’ DNA) and concluded that 14% of the cases were likely to have been caused by either inherited or spontaneous genetic mutations. They believe that with further research and advances in genetic sequencing, it will be established that genetic causes account for up to 45% of cerebral palsy cases.

Recent court decisions

This area of research is proving influential in the conduct of cerebral palsy claims, as demonstrated by two recent interlocutory decisions of the New South Wales Supreme Court. The decisions relate to a matter involving a plaintiff, born in 2003, who suffers from dystonic/spastic cerebral palsy, severe intellectual disability and epilepsy.1 The plaintiff alleged that his condition was caused by trauma sustained in a motor vehicle accident which had occurred when his mother was approximately 25 weeks pregnant.

The defendants, the driver and owner of the motor vehicle involved in the accident, made an application for the plaintiff and his parents to provide blood tests for the purpose of genetic testing. Such testing was considered important following the service of a report by Professor Alastair MacLennan of the Adelaide University cerebral palsy research group. According to Professor MacLennan, there was an increasing understanding that antenatal causes of white matter damage included congenital abnormalities and damage acquired following perinatal infection. On the basis of Professor MacLennan’s report, the defendants were successful in obtaining orders that the plaintiff and his parents supply blood samples for the purpose of genetic testing. The Court ordered that such testing occur given that there was sufficient evidence that the proposed testing had the capacity to assist in relation to the disputed issue of causation.

When the testing did not advance the defendants’ position, the defendants obtained additional expert evidence suggesting that congenital cytomegalovirus (CMV) is best detected using urine, saliva and blood taken within three weeks of birth and that such samples could be obtained by accessing and testing the plaintiff’s Guthrie card (a card used to store dried blood spots routinely obtained from all newborns for the purpose of screening for a range of conditions). On the basis of this evidence, the defendants succeeded in obtaining an order that the plaintiff’s Guthrie card be tested for pre and post-natal congenital infections and conditions including CMV.

As of the time of writing, the results of these tests are unknown.

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1 Sharif Zraika by his tutor Halima Zraika v Walsh [2014] NSWSC 1774 and Zraika v Walsh [2015] NSWSC 645

Comment

These decisions, and the advances that are being made in cerebral palsy research, highlight the complexity of the causation issues that are often inherent in birth trauma litigation. Given the high quantum of such claims, defendants are increasingly going beyond seeking evidence to simply rebut plaintiffs’ causation claims, and attempting to provide the Court with evidence of their own explanations for these tragic outcomes.
Meet our Health Law & Litigation Team

Our team has an in-depth understanding of the health industry and we have significant experience acting on behalf of hospitals, aged care facilities, doctors and other health care professionals.

We are involved in litigated and non-litigated claims, complaints to professional boards and the Health Services Commissioner, Coronial inquests, and are adept at managing complex claims.

We understand that medical indemnity portfolios are highly specialised and require careful management. We know that protecting client reputations in often media sensitive cases and managing claims effectively are key challenges in this area, which we manage carefully and confidently.

We value the strong relationships that we have in place with, and have received compelling endorsements from, our clients and plaintiff lawyers for the speed, commerciality, integrity and intelligent way in which we manage files.

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