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Published in:
Journal of Law and Medicine

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Recommended citation(APA):
Weir, M. (2005). Missed breast cancer: The legal factors. *Journal of Law and Medicine*, 12(4), 511-518.

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12-1-2005

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Michael Weir

Bond University, Michael_Weir@bond.edu.au

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Missed breast cancer: The legal factors

Michael Weir*

Any reading of the relevant legal authorities confirms the special difficulties involved in the diagnosis of breast cancer. In many cases a delayed diagnosis of breast cancer is made at a time when a patient's position has become terminal. It is an easy task for lawyers and expert witnesses to determine in hindsight what should have been done at some point in the past. This article describes how the courts have dealt with this issue and comments on appropriate procedures and approaches to both protect the interests of the patient and confine liability for the medical practitioner.

INTRODUCTION

Missed cancers fall more or less into one of three groups:

1. *Obvious misses*: in these cases for whatever reasons (most often as a result of negligence of some sort) a cancer that should have been ascertained by normal clinical procedures has been missed. Generally, these cases are not particularly legally problematic. By applying the legal tests of competent practice discussed below, a breach of duty may be readily found. The legal task is then to demonstrate that this breach of duty resulted in injury to a patient. The injury is typically a delay in the diagnosis of cancer and the resultant loss of opportunity to obtain a cure or the diminution in life expectancy, pain and suffering and loss of earnings.
2. *Occult cancers*: these are cancers that do exist but are not readily detectable or are not in a form that would raise a suspicion of cancer.
3. *False negatives*: where a lump or other irregularity is found but it is incorrectly diagnosed as benign.

The cases described below normally fall within one of these categories.

The now-familiar test of competence for a medical practitioner is that expounded by the High Court in *Rogers v Whitaker* (1992) 175 CLR 479. The High Court indicated that the law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. The duty is a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment" (at 483). It extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case. The content of the standard of care can vary if the doctor professes to have a particular skill or specialty. The High Court in *Rogers v Whitaker* stated (at 483) that, for specialists: "The standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill".¹ Recent statutory amendments in many jurisdictions² now require greater focus on standard professional practice. These statutes provide generally that a professional does not breach a duty arising from the provision of a professional service if it is established that the professional acted in a way that (at the time the service was provided) was widely accepted as competent practice by peer professional opinion.³

* BA, LLB (Hons), LLM, PhD; Associate Professor, Faculty of Law, Bond University.

Correspondence to: Associate Professor Michael Weir, Law Faculty, Bond University, Gold Coast, Qld 4229, Australia.

¹ See also *Kite v Malycha* (1998) 71 SASR 321.

² See *Civil Liability Act 2003* (Qld); *Civil Liability Act 2002* (NSW); *Wrongs and Other Acts (Law of Negligence) Act 2003* (Vic); *Civil Liability Act 2002* (Tas).

³ *Civil Liability Act 2002* (NSW), s 50; *Wrongs and Other Acts (Law of Negligence) Act 2003* (Vic), s 59; *Civil Liability Act 2002* (Tas), s 22.

Once a duty of care between a patient and doctor is established (this is normally easily done), the court must determine whether the doctor has breached that duty of care. This conclusion is based, in the context of breast cancer detection, upon matters such as:

- whether a palpable lump should have been detected;
- the quality of the physical examination;
- the failure to conduct a physical examination of the patient;
- the failure to order or properly interpret relevant diagnostic tests such as a mammogram, ultrasound and biopsy; and
- the failure to refer to an appropriate specialist.

The failure to diagnose a cancer is not actionable per se. Even if a patient can demonstrate a breach of duty of care in the failure to diagnose a cancer, the patient needs to demonstrate that the failure of a timely diagnosis caused injury (the issue of causation). If, for example, the failure to diagnose cancer would have little impact upon the result – that is, the cancer was already terminal at the time of the error in diagnosis – there may be no liability for the medical practitioner.⁴

In the cases relevant to missed breast cancer, much of the evidence discussed and analysed by the courts relates to whether the medical practitioner has provided treatment in accordance with the usual practice of the profession. In fact, for a lawyer reading those cases, it is often difficult to ascertain where the legal principle starts as against what expert medical evidence suggests is appropriate behaviour.

ARE MEDICAL DOCTORS EXPECTED TO BE PERFECT?

The legal test that is applied in medical negligence cases is not a test of perfection and ultimate care but it does require doctors to use reasonable care. An error of judgment is not necessarily evidence of a breach of duty of care. In *Stacey v Chiddy* (unreported, NSWSC, BC 9303650, 29 January 1993) Levine J stated (at p 15) that the court

is not concerned with absolute scientific certainty, one is not concerned with any standards based on undiluted perfection, but rather the essential question of whether or not his conduct was consonant with the standard of competence expected of a practitioner of his experience.

CASE LAW

A review of many of the cases relative to missed breast cancer reveals a number of striking features that can provide some guidance as to what went wrong in particular circumstances and what steps might have been taken at particular times to avoid the negative result for the patient and the liability of the medical practitioner. This article makes some general comments of broad application and on occasion deals with specific factual circumstances to illustrate a particular point.

Referral of patients

In all areas of medical practice when a general practitioner or specialist is presented with clinical indications that are beyond her or his expertise, he or she should refer the patient to a specialist with appropriate expertise. Although confidence is important in any professional endeavour, an understanding of professional limits and training is also vital for legal and ethical reasons. Drawing on the ethical principle of maleficence – “first do not harm” – suggests the need for medical practitioners to understand and respect their limitations.

In *Tran v Lam* (unreported, NSWSC, 20 June 1997, Badgery-Parker J) a patient sought damages for a failure to diagnose breast cancer. The defendant general practitioner had found a lump in the plaintiff's left breast. Examination by mammography and ultrasound did not suggest the presence of malignancy. The practitioner did not attempt to clarify the diagnosis by needle biopsy but surprisingly attempted to excise the lump in the surgery. This attempt was thwarted by excessive bleeding. It was not until two months later that the client was referred to a surgeon who performed the lumpectomy

⁴ *Barnett v Chelsea and Kensington Hospital Management Committee* [1969] 1 QB 42; *Smith v Lennard* (unreported, NSWSC, 7 September 1994, Studdert J).

that revealed the lump was highly malignant. Although denied by the defendant, the court considered the delay in referral was to avoid the opprobrium associated with the botched procedure (p 19). The cancer had metastasised and at the date of trial the plaintiff was close to death. The court accepted (p 14) that the delay in diagnosis meant the patient lost the chance of a full recovery or at least a longer life. The defendant doctor conceded that the patient should have been referred for a specialist consultation as soon as there was some doubt about the nature of the lump involved. This referral would have resulted in an earlier diagnosis and this delay caused a loss of a chance for a full recovery.

There are many examples where a general practitioner is deemed liable simply on the basis that he or she failed to refer a patient for further tests or examination where the practitioner was dealing with areas in which he or she was inexperienced or not properly trained.⁵ If a referral at an appropriate time would, on the balance of probabilities, have resulted in a better outcome for the patient, there may be liability for the medical practitioner.

Persistent complaints of soreness or discomfort

Particularly relevant to the detection of occult cancers is the need for sensitivity towards patients who persist in complaints of soreness or other concerns where initial tests do not reveal an identifiable irregularity that requires further diagnostic testing. This has been an issue in a number of cases and reflects the protean nature of breast cancer. What might reasonably appear to a diagnostician to be a benign condition may, with the benefit of hindsight, be a possible malignancy that should have attracted a more aggressive response.

In *Holliday v Curtin* (unreported, NSWCA, CAN 40014/97, 15 August 1997) the plaintiff consulted two general practitioners and an endocrinologist about a number of symptoms including acne, hirsutism and on occasion soreness of the breasts. A couple of years later the plaintiff was found to have a metastasised cancer of the breast. At the trial the judge held that at no material time was there a palpable discrete lump of such a kind that a reasonably careful doctor would have detected it and advised of the need for further investigations. Important evidence at the trial dealt with the significance of unilateral breast pain, tender lobularity and general lumpiness.

On the basis of expert evidence, the judge found in favour of the plaintiff. This conclusion was based on his view that even if there was no indication of cancer, the abnormality (a persistent area of lobularity in the left breast, but not the right breast, associated with pain and tenderness) required a prudent medical practitioner to carry out further investigations (p 4). It was found that these investigations would have revealed the cancer that was now terminal.

The unsuccessful defendants appealed to the New South Wales Court of Appeal on the issue of whether what the patient complained of could be considered abnormal. On this point the defendants were successful. The Court of Appeal disagreed with the conclusion reached by the trial judge on the requirement for further investigation where there was no indication of cancer. Clarke AJA held (p 15):

In these circumstances I am not satisfied that the evidence established the existence of a persisting abnormality which would reasonably have put the third defendant on notice that he should require the plaintiff to have investigations for cancer (or at least advise her to have investigations for cancer). Accordingly there is no ground for concluding that the third defendant was negligent. In reaching this conclusion I have not overlooked the fact that tenderness or soreness may properly be regarded as abnormalities and that an area of lobularity was found at the same time. Nor have I overlooked the continued existence of these conditions over a period of a few months, albeit that the soreness and tenderness was improving. The reason why they did not call for the third defendant to refer the plaintiff for an examination designed to determine whether cancer was present is that, although they may fall within the description abnormal, they were not unusual conditions to be experienced by a young woman, they were not indications of cancer, they were readily explicable on hormonal grounds or, possibly, as a reaction to medication and the treating specialist reasonably regarded the lobularity as normal and the symptoms of soreness and tenderness as consistent with her hormonal problems and

⁵ *Mitchell v Health Administration Corp* (unreported, NSWSC, No 322755, 21 December 1995, Studdert J); *Burnett v Kalokerinos* (NSWSC, No 11138 of 1993, Spender AJ).

medication. The case is a long way from one in which the doctor was left scratching his head and saying he did not know the cause of the symptoms and falls outside the purview of those cases in which the patient should, according to Professor Tattersall, be referred.

The legal principles expressed in this case are based on the specific factual situation and care should be taken in extrapolating them too far in other cases. The legal principles arising from them suggest that liability may not attach in cases of occult cancer where it is not possible to ascertain that a potentially cancerous lump exists. However, it does not mean that a medical practitioner need never complete future investigations if vague symptoms do not resolve.

On the other side of the ledger is *Talbot v Lusby* [1995] QSC 143. In this case the plaintiff alleged negligence against a doctor for a delayed diagnosis of breast cancer that precluded treatment early enough to prevent the cancer from metastasising. In February 1989 the general practitioner (qualified as a general surgeon but practising as a general practitioner at the time) was consulted by the patient in her early 30s who complained of a breast lump. The doctor found a large, lumpy, tender area that he suspected was mastitis. He ordered a mammogram that did not reveal anything of significance. He did not order an ultrasound but he suggested she return in two months. When she returned, the area was little changed and he drained two millilitres of fluid that confirmed in his mind the diagnosis of benign cystic hyperplasia. He saw her again two months later and the area had reduced in size. He saw her again two months later and needled what he thought was a cyst but recovered no fluid. He asked to see her again in six months. He saw the patient in October and December 1989 and in March 1990 for unrelated matters where she indicated her concerns about the lump that had not gone away. After feeling back pain in August 1991, she consulted another doctor who recommended a mammogram and ultrasound that revealed cancer that had spread.

The doctor alleged that the cancer only developed after the final consultation and its spread was explicable by the fact that it was an aggressive form of cancer. The judge held:

- The doctor was not negligent in failing to order an ultrasonic scan after the mammography as was suggested by the pathologist. He noted (at [11]): “[N]one of the medical witnesses suggested that the known false negative rate of mammograms ought to lead to the automatic use of ultrasonic scans whenever a negative result was reported in a woman with dense breasts.”
- The judge noted that the doctor should have noted the approximate dimensions of the area of mastitis as it is difficult to differentiate between fibrocystic change and carcinomas. That difficulty suggested that details should have been recorded to assist in the diagnosis. This action may have assisted the doctor in this case though this omission did not result in damage to the plaintiff (at [11]).
- The doctor was not negligent in not doing a further examination when the initial draining of the suspected cyst was clear. This was consistent with mastitis. It was not negligent to reconsider the matter in two months time (at [11]).
- The doctor was negligent after doing the further aspiration of a suspected cyst in August 1989 in not forwarding it for cytological examination or taking some other course of investigation (at [15]-[16]).
- He was negligent in subsequent visits in not ascertaining by physical examination whether the lump had gone away (at [16]).
- The court determined that, although the cancer was not aggressive, if the cancer had been detected in August 1989, when the doctor was deemed negligent, then the cancer would not on the balance of probabilities have spread and would have been treatable. To this extent the patient lost a chance of full recovery (at [11]).

Importance of thorough physical examinations

In many cases doctors have been deemed liable when they have failed to perform a physical examination or have not performed the physical examination competently. In *Stacey v Chiddy* (unreported, NSWSC, BC9303650 No 14352 of 1992, 29 January 1993, Levine J) a general practitioner was subject to a claim that he had been negligent in not detecting breast cancer at a stage when it was treatable. The facts concerned a lump that the patient detected in March 1989. The patient consulted the defendant doctor shortly after. The patient undertook an ultrasound and

mammogram on 21 April 1989 that proved negative. At the consultation the doctor did not examine the patient's breasts. A little over one year later the patient was diagnosed with breast cancer in a similar part of the breast. The doctor argued that this was a new cancer unrelated to the lump detected and investigated the previous year.

In this case Levine J concluded that the medical practitioner had breached his duty of care by not doing a physical examination on 21 April 1989, a few weeks after the initial physical examination. He commented (p 11):

As false negative results in mammograms and ultrasounds are known to occur and are more likely in a mammogram showing dense breast tissue, a significant degree of suspicion should have remained regarding the cause of the breast lump.

I believe that if any undiagnosed breast lump remained palpable then the correct course of action would have been to review the lump over the following month. If the lump remained palpable the patient should have been referred for a definite diagnosis and treatment recognising that breast cancer left untreated carries increased mortality.

Levine J concluded that, if the examination had been performed and the lump remained, the normal regime would have been to refer the patient to a surgeon for further assessment and biopsy. If the lump was still palpable, any recommendation to come back in three months was too long, given the negative result from the mammogram and ultrasound. Any opportunity that arose to re-examine the patient should normally have been taken (p 14).

Despite this breach of duty, the doctor was able to resist the claim made against her because causation was not proven. It was not possible to conclude that the lumps detected in 1989 were simply the beginnings of the cancerous lesions detected in 1990 or that they were cancerous in April 1989. This meant that the plaintiff was unable to prove that proper investigation at that time would not have avoided the clinical outcome (p 23) – that the breach of duty caused the adverse outcome.

The issue of physical examination was fundamental to the determination of a negligence claim in *Putnam v Huber* (unreported, NSWSC, BC 9102666, No 12691 of 1990, 18 February 1991, Studdert J). This case may be considered to be within the “clear miss” category. In this case the plaintiff suggested that the general practitioner, when assessing a 38-year-old patient in May 1989 with costochondritis and tenderness in the thoracic area, should have considered the possibility that this was an indication of possible breast cancer that was diagnosed five months later. It was only in September 1989 that the doctor detected a swelling and ordered an ultrasound examination leading to a diagnosis of breast cancer. The judge preferred the plaintiff's evidence (that contradicted the doctor's evidence) that she did tell the doctor of a lump but he concluded that it was tietsi synovitis (p 2). When asked whether it could be cancer, the doctor answered that all women with that condition think it is cancer. The doctor denied that he was advised of a lump when the patient first visited him in May 1989 and on that basis he did not examine the client's breasts but examined other parts of her body consistent with his diagnosis. The patient's version of events was preferred, based upon the judge's assessment of the veracity of her evidence and some corroboration of the existence of the lump. On that basis, the judge concluded that, despite being referred to the lump in question, the doctor did not detect the lump on that examination. Studdert J concluded (p 15):

[A]ssuming the plaintiff presented herself to Dr Huber making the complaints which I have found she did make the exercise of reasonable care by the doctor required of him that he make a careful examination of the plaintiff and on detection of the lump that he investigate the possibility that it was a carcinoma. I am satisfied that its presence [the lump] would have been detectable on careful examination.

In *Brown v Willington* [2001] ACTSC 100 the plaintiff was diagnosed with a lobular carcinoma in the left breast. The plaintiff noticed two lumps in her breasts in August 1995, one near the nipple and the other on the upper left quadrant. Physical examination by the first defendant doctor confirmed this and she was referred for a mammogram, ultrasound and needle aspiration if required. The patient was incorrectly told by a person at the local hospital that she could not have a mammogram while breastfeeding as her breasts were too dense. The mammogram done six months later was negative.

The ultrasound was done in August 1995, after which she had a conversation with the third defendant, a physician in nuclear medicine and diagnostic ultrasound. She was told that, as she was

only 35 years old and had no family history of breast disease, there was no need to worry. She was told her previous history of thyroid cancer did not impact on this advice. The third defendant did not examine the plaintiff's breast by palpation. The report from that referral noted some "mildly dilated lactiferous ducts" near the nipple of the left breast but no other significant irregularities. The patient returned to have another ultrasound in December 1995 as the lumps had persisted. A fine needle aspiration from the left breast nipple area (but not the upper left quadrant) was done without any physical examination. The cytology did not reveal irregularity but a mammogram was suggested.

A subsequent doctor referred the plaintiff to a surgeon who, with a subsequent ultrasound and mammogram suggesting fibroadenosis and a false assumption that the aspiration (done in December 1995) had been taken from the lump in the left quadrant, diagnosed a benign lump. After urging from the referring doctor shortly after, the surgeon performed an excision biopsy that revealed a multifocal invasive lobular carcinoma in the upper left quadrant. At the time of trial the death of the plaintiff from metastatic cancer was inevitable.

Crispin J made a finding of negligence against the third defendant on the basis of his failure to carry out a proper or adequate physical examination of the plaintiff's left breast in August and December 1995 (p 8).⁶ If properly performed, the judge concluded it would have revealed the presence of the lump in the upper left quadrant and that he then would have, or should have, performed a fine needle aspiration of that area. He noted that his attention had been drawn to both areas by the referring doctor and the patient. This procedure would have revealed a lobular carcinoma and earlier treatment would have been provided. The judge concluded (p 9):

[A] reasonable standard of care on the part of a person in the position of the third defendant would have involved the application of the so called "triple test" for any lump in the breast at least in the absence of any obviously benign explanation. The triple test consisted of a clinical examination, imaging by mammography or ultrasound, and fine needle aspiration or biopsy. I was satisfied that this standard required a person in the position of the third defendant to apply the triple test to both "lumps" and not merely to the one in the areola.⁷

Use of the diagnostic triad

A doctor may appropriately be concerned about the cost, the pain and the inconvenience of some tests and may prefer a more conservative approach. In addition, some diagnostic tests have false negative rates and may be unsuccessful in ascertaining the required information. The most accurate techniques, such as excision biopsy, may be the most invasive.

Despite these concerns, an adverse judgment is common when there is a failure to apply the triad of techniques and as a result a breast cancer is missed. The approach of the courts appears to be that, where a clinician suspects that cancer is a possibility, a diagnosis of cancer should be excluded with rigorous initial investigation (p 9).⁸ This suggests that, if investigations reveal that breast cancer is a possibility, the diagnostic triad should be applied to confirm or deny this possibility unless circumstances suggest this approach is not indicated.

In *Holliday v Curtin* (unreported, NSWCA, CAN 40014/97, 15 August 1997, p 15) the doctors were deemed not to have acted negligently in not applying the diagnostic triad when a patient complained of general tenderness. As the patient was young and the clinical evidence suggested the tenderness may have been hormonal and a reaction to medication, the approach of the doctors was supported.

In *Tran v Lam* (unreported, NSWSC, 20 June 1997, Badgery-Parker J), although the doctor had received a negative result on the mammogram and the ultrasound, the fact that the doctor did not within a reasonable time refer the patient for a biopsy was the basis of her liability (p 13). In *Brown v Wellington* [2001] ACTSC 100 the failure of a physician in nuclear medicine and diagnostic ultrasound to perform a physical examination and to obtain evidence from the second and most significant lump was the vital error by the medical practitioner in that case (at [8], [10]). The significant breach of duty in *Talbot v Lusby* [1995] QSC 143 was the fact that the doctor had failed to

⁶ This was confirmed on appeal in *Mouratidis v Brown* [2002] FCA 330 at [45]-[48].

⁷ This was confirmed on appeal in *Mouratidis v Brown* [2002] FCA 330 at [45]-[48].

⁸ *O'Shea v Sullivan* (1994) Aust Torts Reports 81-273 at 61,299.

obtain cytology evidence from a fine needle aspiration that appeared to have failed to provide any evidence (at [15]-[16]).

Although there appears to be a need to act quickly to establish whether a lump is cancerous or not, there appears to be an acceptance that, where there are no obvious indications of cancer after a mammogram and ultrasound, it may be appropriate to delay for a short period. This can assist in establishing if a lump is hormonal and will resolve within that month or if it requires further investigation.⁹ In *Wharton v Garne* (unreported, NSWSC, BC 9803714 21285/95, 12 August 1998, Dunford J) it was held (p 7) that if a lump persisted after three months a referral for a fine needle biopsy or a referral to a specialist for this type of investigation was necessary. This approach should be coupled with counselling a client that she should return for further examination after that period and for a record to be kept of the dimensions of the lump for later comparison.¹⁰

Importance of competent and complete clinical records

The quality of records kept by doctors has an impact on their chances of successfully defending an action against them. It is clear that an important aspect of a trial is determining what was said by whom and at what time. This is done in a pressured litigious environment and will often involve an assessment of inconsistency in evidence between the accounts of the plaintiff and the defendant. A judge will be obliged to assess, often with a lack of objective evidence, on the balance of probabilities, what has happened at a particular time. This assessment may be based upon recollections put into evidence years after the event. Often the result of litigation will hinge on the credibility of the plaintiff and defendant when giving evidence-in-chief and under cross-examination and the credibility and quality of expert witnesses. An important aspect of this process is the reference made to a doctor's records. A doctor who cannot refer to clear, contemporaneous notes to support her or his version of events will be at a disadvantage.

This aspect impacts on litigation in the following ways:

- A doctor who can demonstrate a history of good records can more easily argue that an absence of a detail in medical records may reflect what actually happened between patient and doctor. Good records may suggest a patient failed to describe a symptom, to complain of a lump or to instruct the doctor on an issue that may be a factor in the litigation. In *Holliday v Curtin* (unreported, NSWCA, CAN 40014/97, 15 August 1997), the Court of Appeal noted (p 4) that the trial judge:

found that all the defendants were good note takers and the third defendant was a most meticulous note taker. Having regard to the notes and the evidence of the doctors, his Honour was quite satisfied that neither the second nor the third defendant ever palpated a discrete lump in the sense referred to. His Honour was also of the view that it was highly unlikely that the first defendant would have failed to record a finding that she had made of such a discrete lump.

Unlike the approach followed in many cases, in this case the judge preferred the evidence of the doctors over the plaintiff.

- It demonstrates a professional approach to their tasks that will create a good impression for a judge.
- Records can provide the best record of what the doctor states occurred and what might have been in her or his mind at the time.
- If gaps are left in the records, a judge is forced to make assumptions and may rely on a patient's recollection of events and this will impact on the view taken of the reliability of the doctor's evidence.¹¹

Provision of information to patients

An aspect of the duty of a medical practitioner is to provide a patient with the necessary information to make informed decisions such as the decision to proceed with a procedure knowing all the inherent

⁹ See *Holliday v Curtin* (unreported, NSWCA, CAN 40014/97, 15 August 1997), p 15.

¹⁰ *Tran v Lam* (unreported, NSWSC, 20 June 1997, Badgery-Parker J), p 13.

¹¹ *Tran v Lam* (unreported, NSWSC, 20 June 1997, Badgery-Parker J), p 3; *Putnam v Huber* (unreported, BC 9102666, No 12691 of 1990, 18 February 1991, Studdert J), p 8.

risks of treatment. The principles described in *Rogers v Whitaker* (1992) 175 CLR 479 at 483 apply to the provision of information to a patient.

It is a part of the role of a medical practitioner to advise a patient of the possible presence of cancer when this is uncertain and counsel the patient about the need to attend to recommended diagnostic and treatment options. This was a factor in *O'Shea v Sullivan* (1994) Australian Torts Reports 81-273, a case involving cervical cancer. In that case an attempt by the defendant doctor to claim contributory negligence by the plaintiff in not following up treatment was stymied by the fact that the doctor had not provided the required information to alert the client to the possibility that she had cancer (at 61,313).

If a doctor advises a client to wait for a period of two to four weeks before further tests, it is part of the duty of care to ensure that the client is counselled about the need to return for further physical examination with that request being followed up.¹²

Not providing that information may affect the ability to infer contributory negligence on the part of a patient. A medical practitioner will be better placed if a client fails to return for further investigation after being given careful information about the fact that the investigations had not yet excluded the possibility of cancer. This was a relevant factor in *Kite v Malycha* (1998) SASR 321 where the failure of a doctor to follow up a cytology report was not reduced by the patient's failure to check on the result because the patient assumed she would be contacted about an adverse result. In *Tran v Lam* (unreported, NSWSC, 20 June 1997, Badgery-Parker J), although it was accepted that a doctor could delay further investigation after receiving a negative result on initial tests, the doctor should counsel the client about the need to return for those further tests (p 23).

CONCLUSION

These principles provide a summary of many important factors in the tasks faced by medical practitioners when dealing with breast cancer. The review of relevant authorities reveals the necessity for medical practitioners to be able to align their practice with standard medical procedures as ultimately this is their best defence against a claim of negligence. In addition, careful attention to detail in record-keeping, in assessing medical test results and physical examination is fundamental.

Although reform of the law of negligence will assist the position of medical practitioners, attention to the issues discussed above and emphasis upon communication between patients and doctors will increasingly be at the basis of considerations by the courts when faced with claims of negligence.

¹² *Tai v Hatzistavrou* [1999] NSWCA 306.