*Jaensch v Campbell* [2001] NTSC 87

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| PARTIES: | TERESITA JAENSCH |
| | v |
| | DANIEL CLIFFORD CAMPBELL |
| TITLE OF COURT: | SUPREME COURT OF THE NORTHERN TERRITORY |
| JURISDICTION: | SUPREME COURT OF THE NORTHERN TERRITORY exercising Territory jurisdiction |
| FILE NO: | 156 of 1997 (9715713) |
| DELIVERED: | 17 October 2001, Darwin |
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| JUDGMENT OF: | THOMAS J |

**CATCHWORDS:**

MEDICAL NEGLIGENCE – PROOF OF NEGLIGENCE

Duty of care – duty to warn of possible consequences of surgery – substantial aspect of claim in negligence not established

Standard of care – requisite standard of care of post operative treatment – failure to maintain required standard of care – damages for distress and discomfort

*Rogers v Whitaker* (1992) 175 CLR 479, cited

**REPRESENTATION:**

*Counsel:*

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| Plaintiff: | J Reeves QC |
| Defendant: | R Bruxner |

*Solicitors:*

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| Plaintiff: | Ward Keller |
| Defendant: | Morgan Buckley |

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| Judgment category classification: | C |
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| Number of pages: | 59 |

IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

*Jaensch v Campbell* [2001] NTSC 87
No. 156/1997 (9715713)

BETWEEN:

**TERESITA JAENSCH**
Plaintiff

AND:

**DANIEL CLIFFORD CAMPBELL**
Defendant

CORAM: THOMAS J

REASONS FOR JUDGMENT

(Delivered 17 October 2001)

[1] This is a claim for damages by the plaintiff. The plaintiff alleges these damages were caused by the negligence of the defendant. The defendant denies any such negligence.

[2] The defendant was at all material times a medical practitioner and carried on practice as a general surgeon on premises located at Rocklands Drive, Tiwi in the Northern Territory known as Darwin Private Hospital.

[3] The plaintiff was at all material times a patient of the defendant.

[4] On or about 9 March 1995, the plaintiff underwent a left radial mastectomy in respect of cancer of her left breast and lymph nodes performed at the hospital by Dr Gamal Mousa, the plaintiff's then general surgeon.

[5] The plaintiff claims she was anxious about a recurrence of the breast cancer in her right breast. She consulted the defendant about the removal of her right breast. On 9 December 1996 the defendant performed upon the plaintiff the treatment being a right subcutaneous mastectomy.

[6] The plaintiff remained a patient at the hospital under the care of the defendant until approximately 15 December 1996.

[7] On or about 1 January 1997, the plaintiff attended the accident and emergency department of the hospital and complained of excessive pain and smell in her right chest area. The plaintiff was attended by a duty doctor. The records of the Accident and Emergency Department of the Royal Darwin Hospital indicate:

> The wound smelly – necrotic skin below nipple.
> Moderate erythema – presumably infected.
> Dress wound.
> Sorbosan dressing applied.
> IM Rocephlin 1 g given in each buttock.

[8] On or about 2 January 1997, the plaintiff attended the accident and emergency department of the hospital for review. The duty doctor provided the following treatment:

> The plaintiff's wound was cleansed and redressed with Sorbosan.
> The plaintiff was advised to see the Defendant on his return from leave.

[9] Subsequently, the plaintiff consulted the defendant in respect of her condition. This was on or about 6 January 1997. The plaintiff alleges in her amended statement of claim filed 9 June 2000 that the defendant confirmed she had developed gangrene around her nipple area. The plaintiff further alleges that when she asked the defendant why the gangrene had developed, the defendant had replied words to the effect; "the gangrene has been caused because the blood vessels of your right chest area were not properly connected to the nipple area during the operation". The defendant denies these allegations.

[10] The defendant subsequently removed the gangrene from around the nipple area of the defendant's right breast. The plaintiff claims this was performed in the defendant's rooms in the presence of the plaintiff's daughter and requested that the plaintiff's daughter assist with the procedure. This caused the plaintiff further embarrassment and discomfort.

[11] The plaintiff claims the defendant negligently failed to exercise reasonable care in or about the said treatment which he gave to the plaintiff, the particulars of which are as follows:

"**Particulars**

(a) Failed to advise or warn the Plaintiff properly or at all of any material risk inherent in or relating to the proposed treatment generally or in particular in relation to the preservation of the Plaintiff's right nipple.

(b) Failed to advised or warn the Plaintiff properly or at all of the possibility of the development of gangrene following the treatment.

(c) Failed to properly connect blood vessels to the nipple region of the Defendant's right chest during the treatment.

(d) Failed to ensure proper management and monitoring of the Plaintiff's post treatment recovery so as to avoid and/or reduce the likelihood of the development of gangrene after the treatment.

By reason of the Defendant's breaches the Plaintiff has suffered injury, loss and damage.

**Particulars of Injury**

(a) Severe pain and suffering.

(b) Loss of enjoyment of life.

(c) A large and unsightly hole in the area of the nipple on the Plaintiff's right chest.

(d) Significant scarring on the Plaintiff's right chest.

(e) Inability to undergo reconstructive surgery with respect to the Plaintiff's right and left breast.

**Particulars of Loss and Damage**

(a) The Plaintiff has incurred medical, hospital and pharmaceutical costs.

(b) The Plaintiff claims loss of income arising from her injuries.

(c) The Plaintiff claims general damages for pain and suffering and loss of enjoyment of life.

By reason of the Defendant's negligence the Plaintiff has and continues to suffer loss and damage."

[12] There is no dispute that Dr Campbell owed a duty of care to Mrs Teresita Jaensch. Nor is there any dispute that performance of that duty entailed the provision of a warning of the possible side effects of the subcutaneous mastectomy as well as the provision of suitable post operative care.

[13] Mrs Jaensch has two basis for her claim in negligence:

1) No warning of the possible side effects of the subcutaneous mastectomy was given.

2) The post operative treatment fell short of the requisite standard of care.

[14] The onus is upon Mrs Jaensch to satisfy the court on the balance of probabilities that the duty of care was breached and that she suffered damage as a consequence of the breach.

[15] The plaintiff, Mrs Jaensch, gave evidence on 11, 12 and 13 July 2000. At that time the plaintiff was also giving evidence in respect of her action against Dr Mousa, claiming negligence in respect of an alleged failure to properly diagnose a cancer in her left breast. In 1995, Mrs Jaensch underwent a mastectomy to her left breast. It was following this operation and subsequent chemotherapy treatment that Mrs Jaensch consulted Dr Campbell in respect of her right breast.

[16] The action against Dr Mousa concluded when the plaintiff filed a notice of discontinuance on 19 March 2001 following settlement of the action against Dr Mousa. The hearing of the action against Dr Campbell resumed on 21 May 2001 and proceeded for hearing to 5 June 2001. The exhibits that relate to the plaintiff's action against Dr Campbell commence with Exhibit P9.

[17] On the morning Mrs Jaensch commenced giving evidence being 11 July 2000, the court was informed that Mrs Jaensch was taking pain killers including Panadeine Forte and morphine. The effect of the morphine was to make her confused and unable to concentrate. I do take into account the

circumstances under which Mrs Jaensch was giving evidence which for her were extremely difficult.

[18] At the date of giving evidence Mrs Jaensch had been in receipt of a disability pension since about May 1998. Mrs Jaensch gave evidence as to the effects of the medication she was taking which was that she became confused, had difficulty concentrating and remembering.

**Summary of the evidence of the plaintiff Mrs Teresita Jaensch**

[19] It is Mrs Jaensch's evidence that following her chemotherapy and radiotherapy treatment in Adelaide in respect of her left breast she returned to Darwin and consulted Dr Campbell. Dr Campbell had taken over Dr Mousa's practise. Mrs Jaensch stated she asked Dr Campbell to take a biopsy of her right breast. Dr Campbell had advised that this could not be done. Mrs Jaensch states she told him she wanted to get rid of the right breast because she did not want any more risks. Dr Campbell had advised her to wait. Mrs Jaensch said she returned in three or six months time. Mrs Jaensch asked him again to remove her right breast. Dr Campbell had agreed to do the operation. Dr Campbell advised her it was a fairly simple operation and asked her if she wanted to retain her right nipple. Mrs Jaensch had replied yes if it means no complications. Dr Campbell had stated there was no problem. Mrs Jaensch was admitted to hospital on 9 December 1996. Mrs Jaensch says Dr Campbell did not tell her about the risk of infection, he did not mention infection or any other risk associated

with the procedure. The operation was performed. Instead of remaining in hospital for three days as Mrs Jaensch had been informed, she was there for seven days.

[20] The day after the operation Dr Campbell attended upon her, he took off the dressing and examined her breast. It is Mrs Jaensch's evidence that Dr Campbell did not remove the dressing again after this occasion, he only had a look. A nurse had changed the dressing the day she left hospital.

[21] Mrs Jaensch stated that her right breast started oozing pus and there was a strong, horrible smell. She felt numbness and pain. The last day Mrs Jaensch saw Dr Campbell was the day she was discharged. Dr Selva did attend on her at hospital at the request of Dr Campbell. Dr Campbell had previously referred Mrs Jaensch to see Dr Selva, who was the oncologist in charge.

[22] After she had been discharged home she noticed the wound appeared all brown and mucky, there was a smell and it was painful. Mrs Jaensch was told Dr Campbell was on holidays. She went to the accident and emergency section at Royal Darwin Hospital. The doctor she saw advised her she had surface gangrene. She returned to see Dr Campbell early in January. Dr Campbell cut out the gangrene with the assistance of Mrs Jaensch's daughter Erika who is a medical student. Dr Campbell cut a hole 1½ to 2 inches across her breast and cut out her right nipple. Dr Campbell told her it was gangrene. Arrangements were made for her to be attended by community

nurses who visited Mrs Jaensch twice a week. It is Mrs Jaensch's evidence that eventually the breast healed but was very deformed. There was no comparison between her right and left breast.

[23] Mrs Jaensch gave evidence that if Dr Campbell had told her there were risks if she kept the nipple she would have told him not to keep it but to take the whole thing off.

[24] At the request of the parties arrangements were made for the Court to view Mrs Jaensch's right and left breast. This was done in a room adjacent to the Court. The persons present included counsel and their instructing solicitors and Mr Wallbridge who operated the video.

[25] The following is an agreed summary of the view as it pertains to the claim against Dr Campbell:

[26] Mrs Jaensch identified her right breast where a subcutaneous mastectomy was carried out by Dr Campbell. In respect of her right breast, there had previously been a hole in the area of the nipple of that breast. Mrs Jaensch stated that the community nurses had filled the hole with a form of seaweed. Mrs Jaensch indicated an area of flab to the right of her right breast and stated that this is now less bulky than it had previously been. Mrs Jaensch pointed to scarring where the gangrene had occurred and where drainage tubes had been used in her treatment.

[27] Mrs Jaensch also identified the area above her right breast where a lumpectomy had been performed by Dr Wardill in 1992. She indicated that there had been scarring from that operation around the areola of her right breast. Mrs Jaensch stated that this scarring was no longer evident subsequent upon the further operation to her right breast to remove the gangrenous part of the flesh around her right breast.

[28] Finally, Mrs Jaensch was shown four photographs which were subsequently tendered Exhibit P10. Mrs Jaensch stated these photographs had been taken some weeks previously.

[29] Under cross examination Mrs Jaensch said when she first consulted Dr Campbell she had told him she was not happy about having a right breast mammograph because "nothing show on either side, nobody believed me there was a problem there." I understood this to be a reference by Mrs Jaensch to her claim that the mammograph had failed to show a problem with her left breast.

[30] Mrs Jaensch agreed that Dr Campbell did carry out a fine needle aspiration at her request. Mrs Jaensch agreed she had suggested the removal of her right breast because of what occurred to her left breast. It is her evidence that she was worried there might be a recurrence of the cancer, this time, in her right breast. Mrs Jaensch agreed that at her first consultation with Dr Campbell she had requested a mastectomy of her right breast. Dr Campbell had asked her to leave it for a while and think about it.

[31] Mrs Jaensch then referred to a second consultation with Dr Campbell. She stated she did not know there were two types of mastectomy. All she wanted was her right breast removed so that the cancer would not travel to the right breast. It is Mrs Jaensch's evidence that there was no discussion of what was involved in a mastectomy. Dr Campbell had said there is no problem with the operation, it is fairly simple. He had not said anything about the nipple. On further questioning Mrs Jaensch agreed that Dr Campbell had asked her if she was intending to have a reconstruction and if that was the case did she want to retain the nipple. Mrs Jaensch stated Dr Campbell did not say anything to her about the different possibilities for reconstruction, that it would make it a cosmetically better result if the nipple was still there or that there would be a cosmetically better result if the skin was still there.

[32] It is Mrs Jaensch's evidence that Dr Campbell told her she would be in hospital for three days. In fact she stated she was in hospital for seven days. Her evidence is the operation was performed the day after she was admitted to hospital. There was one large dressing around her right breast in the area of the nipple. Mrs Jaensch said that underneath the dressing she thought it would be something like her left breast but agreed that when she went into the operation she knew that the nipple would be retained but had not received an explanation as to how this was to be done. There was a drainage tube attached to her right breast to drain any liquid not supposed to be there. Mrs Jaensch stated that Dr Campbell had not given her any explanation

about the tube or its purpose. Whilst she was in hospital the pain remained constant. The pain became worse after she was discharged and the smell started after she had returned home. The last day Mrs Jaensch stated she saw Dr Campbell was the day before her discharge. It was Dr Campbell's decision that she be discharged. Mrs Jaensch did not recall Dr Selva examining her. She states she was not told what she needed to do with her wound. She says using her own common sense she changed the dressing every day after she had been discharged from hospital. Mrs Jaensch stated she was certain she did not see Dr Campbell the day after her discharge or two days before Christmas on 23 December 1996. Mrs Jaensch agreed she did see Dr Campbell on 6 January 1997. At that time she was accompanied by her daughter Erika. Dr Campbell removed the gangrene. Mrs Jaensch could not recall if her daughter helped or just watched. There was a hole where her skin was removed and the nipple was gone. Mrs Jaensch described the location of the scarring as being where the nipple is supposed to be. It is bulky. Mrs Jaensch stated she thought it would be nearly impossible to do a reconstruction but agreed that she had not consulted a doctor about this. Mrs Jaensch denied that Dr Campbell had told her that cosmetically she could get a better result if the skin and the nipple were retained. Mrs Jaensch denied the photos (Exhibit P10) showed there was a scar above her right breast and to the right. When it was put to Mrs Jaensch that at the view it was plainly apparent that there was a nipple present in the fold of her right breast she stated that there was no nipple.

[33] Mrs Jaensch agreed under cross examination that at the time she first saw Dr Campbell she had been through a lengthy period of chemotherapy and radiotherapy. This had caused pain, discomfort and isolation. She had been distressed and in pain for a long time. The medication had caused uncomfortable side effects and periods of isolation in hospital wards. Mrs Jaensch stated she was suing Dr Mousa because he had failed to diagnose the left breast cancer which led to her problems. Mrs Jaensch agreed she felt cheated and frustrated, hated hospitals and mistrusted doctors.

[34] By the time she went to see Dr Campbell her wish was to try and rule out any chance of there being any cancer in her right breast. She agreed she told Dr Campbell she was worried because of the earlier failure to diagnose cancer in her left breast.

[35] It is Mrs Jaensch's evidence that at the first meeting with Dr Campbell he asked her to give some further thought to whether she should proceed with a mastectomy to her right breast. At that first meeting nothing final was decided about the mastectomy.

[36] At the second meeting in October, Mrs Jaensch had told Dr Campbell she wanted a mastectomy. This was because of her concern that there was no certain way of detecting cancer. Mrs Jaensch said she did not want to take the risk of cancer in her right breast. Mrs Jaensch states Dr Campbell did not tell her anything about either a simple mastectomy or the subcutaneous mastectomy. Mrs Jaensch stated Dr Campbell did not examine her but

agreed under further cross examination it was possible he did, she could not recall.

[37] Mrs Jaensch stated she did not recall Dr Campbell saying anything about what is involved in a simple mastectomy and a subcutaneous mastectomy. She states Dr Campbell did not tell her that there was a risk the operation could cause problems with the blood supply to the breast skin. He did not tell her this could affect the nipple or that blood supply problems could lead to some of the skin dying. Mrs Jaensch stated that Dr Campbell did not explain that the nipple could be lost nor that the same problem as was possible with the skin could also happen with the nipple. Mrs Jaensch says Dr Campbell did not tell her that after the operation there would be the need to drain fluid which would collect in her breast nor that there was a risk there would be haemorrhaging. A number of matters were put to Mrs Jaensch in cross examination about what was involved in a subcutaneous mastectomy. Mrs Jaensch denied Dr Campbell told her about any of these procedures.

[38] Mrs Jaensch stated that when she went to see Dr Campbell she had made up her mind to go ahead with breast reconstruction if there were no complications such as infections and no after effects. Mrs Jaensch said she was in two minds, one her fear of hospital and doctors, and the second a bit of vanity. Her evidence is Dr Campbell said nothing to her about the cosmetic side of things. She was not aware that at the time of performing a subcutaneous mastectomy it was possible to insert a saline implant at the

time of operation. Mrs Jaensch referred to experiments in England concerning live breast reconstruction. She stated that she would have done this in a few years, because she wants to remain a woman.

[39] Mr Bruxner, counsel for Dr Campbell, put to Mrs Jaensch a series of meetings that Dr Campbell stated he had with Mrs Jaensch which included 17 November 1995, a date in January 1996, 21 March 1996 and 2 April 1996, about a month before the first meeting they had when there was a discussion about the possibility of a mastectomy. Mrs Jaensch stated she did not recall any of those meetings.

[40] Mrs Jaensch denied that the day after her discharge from hospital she saw Dr Campbell in his surgery on 16 December 1996 and that he examined her and told her that there was evidence on her breast of the sort of problems with blood supply that he had earlier warned her about, that he noted a discharge and prescribed antibiotics.

[41] It is Mrs Jaensch's evidence that the first time she saw Dr Campbell after leaving hospital was on 6 January 1997. She denied that she saw him two days before Christmas on 23 December 1996.

[42] Mrs Jaensch agreed that when she saw Dr Campbell on 6 January he noted that the skin on her breast had completely died and he proceeded to remove that skin and the tissue beneath. Mrs Jaensch stated that the nipple was lost at that time. Mrs Jaensch agreed in cross examination that she does not recall seeing Dr Campbell after 6 January but stated it is possible that she

did. Mrs Jaensch stated that Dr Campbell saw her every day in hospital after the operation.

[43] It is Mrs Jaensch's evidence that if she had known there was a risk of infection she would not have had a mastectomy. She agreed that she did want a mastectomy because she was worried about cancer. Her evidence is that if she had known about the risk of infection she would probably have sought a second opinion. Mrs Jaensch denied that Dr Campbell had told her that there was a risk that there would be skin which might die following the right subcutaneous mastectomy. She stated Dr Campbell did not warn her that what happened to her right breast might happen.

[44] (t/p 208) Mrs Jaensch agreed that at the second meeting with Dr Campbell in October 1996, he had told her there was no evidence of cancer in her right breast.

[45] In re-examination, Mrs Jaensch gave evidence that a lumpectomy on her right breast performed by Dr Wardill was around the nipple. A lesion on her right breast was removed by Dr Mousa about two to three inches above the nipple towards the outside of her body.

[46] This concludes my summary of the evidence given by Mrs Jaensch.

**Summary of the evidence of the defendant Dr Daniel Clifford Campbell**

[47] Dr Campbell gave evidence that he is a specialist surgeon practising at Darwin Private Hospital. Dr Campbell has a Bachelor of Medicine and a Bachelor of Surgery and is a Fellow of the Royal Australasian College of Surgeons. Dr Campbell stated he practised in association with Dr Gamal Mousa from 1990 to 1995. When Dr Mousa departed in 1995 Dr Campbell took over some of Dr Mousa's patients, including Mrs Jaensch. From September 1995 to January 1997, Dr Campbell was involved in the care of Mrs Jaensch. Dr Campbell stated he carried out a physical examination of Mrs Jaensch and noted that she had radical surgery (t/p 130) due to left breast cancer and had a modified radical left mastectomy. She had radical adjuvant therapy post operatively, including radio therapy and chemotherapy and had spent an extended time in Adelaide for this treatment.

[48] In December 1996, Dr Campbell performed a subcutaneous mastectomy. Dr Campbell stated that he has been involved with thousands of operations. Subcutaneous mastectomy is not a common operation and up until December 1996, Dr Campbell would have performed 20 to 30 such operations. The primary reason for a subcutaneous mastectomy on women is for cancer phobia or a serious family history of breast cancer, the next priority would be for a condition of severe breast pain or mastalgia. The aim of a subcutaneous mastectomy is to re-size actual breast tissue, preserving the contour of the skin and the nipple complex. The operation is predicated by

the size of the breast. The aim is to preserve blood supply to the skin and subcutaneous tissue but also be mindful of the fact that you have to excise breast tissue. Dr Campbell described the method of the operation. It is Dr Campbell's evidence that because of the broad based area of dissection, there is always some oozing and/or some bleeding. Drains are always inserted after the procedure and the wound closed with a subcuticular suture. This is designed to preserve the cosmetic appearance of the wound. The operation is designated as potentially a cosmetic operation for future reconstruction, but the nature of the operation does leave it prone to a risk of ischaemia, which is lack of blood supply to the breast skin. This can result in varying degrees of necrosis after the operation. Necrosis is development of non-viable tissue. It is usually obvious visibly by its change in colour. With time it becomes a definite demarcation or geographical line of demarcation which is the definite demarcated area of necrosis beside a viable or vital tissue. Ischaemia can happen rapidly. It can also be a slow process eventuating in necrotic tissue. Signs of ischaemia should be responded to by observation and care and an attempt to pre-empt the onset of infection by instituting antibiotic treatment.

[49] Mrs Jaensch had a cancer phobia and was extremely anxious about the onset of another cancer in her right breast. One option is to remove the breast by a simple mastectomy in which the breast and nipple complex are lost leaving a scar extending laterally across the chest. The other option is a subcutaneous mastectomy. A subcutaneous mastectomy was performed on

Mrs Jaensch in December 1996. The decision to do this was made in consultation between Dr Campbell and Mrs Jaensch in October 1996. There had been a discussion in May 1996, however, Dr Campbell had considered it was too precipitous to proceed with a mastectomy at that time. Dr Campbell stated he had examined Mrs Jaensch's breast for re-current breast tumour and re-assured her that everything was going along fine. In October 1996, Mrs Jaensch initiated the topic of mastectomy. Dr Campbell stated he explained to Mrs Jaensch that a simple mastectomy would have been an easier operation but it would be difficult to perform reconstruction at a later time. A subcutaneous mastectomy preserves the nipple and is eminently suitable for later reconstruction.

[50] In October 1996, Mrs Jaensch had told Dr Campbell she did not want the right breast. She had said to him that last time there had been a missed diagnosis with respect to her left breast and she did not want that to happen again. Dr Campbell stated he explained to her the difference between a simple mastectomy and a subcutaneous mastectomy and that a simple mastectomy was an easier operation. Dr Campbell gave evidence he explained to her that a subcutaneous mastectomy preserves the contours of breast skin and nipple. It is eminently suitable for reconstruction at a later date. At the end of the consultation, Mrs Jaensch signed up for a subcutaneous mastectomy.

[51] Dr Campbell described the operation he performed on Mrs Jaensch. Dr Campbell stated he was happy with the operation and with the state of

health of the breast. Mrs Jaensch was in hospital for six days. This is longer than normal. Dr Campbell stated he saw Mrs Jaensch on a daily basis following the operation. On the first day he noted the skin was becoming dusky in the centre. The immediate implication is that there is an area of decreased blood supply to the central area of the wound (t/p 142).
Dr Campbell stated he wanted to mitigate against any extension of the ischaemic area. It is Dr Campbell's evidence that he was happy with the surrounding or peripheral breast skin, surgically there was nothing to be done. It was a matter of careful watching and monitoring. The major concern was the evolvement of infection because this would potentially increase the area of skin at risk. Upon making this observation, Dr Campbell initiated some intravenous antibiotic therapy. Dr Campbell gave evidence that he saw Mrs Jaensch on 9, 10, 11, 12, 13 and 14 December 1996, and inspected her wounds. The area of ischaemia was confirmed. It slowly evolved over the next few days. Surgical intervention would have been inappropriate. It was Dr Campbell's impression that if there was an area of necrosis that developed it would be a small area.

[52] Dr Campbell stated he remembered a time just after New Years Day in 1997 when Mrs Jaensch and her daughter attended his rooms. Dr Campbell's record cards (Exhibit D19) indicate this was 6 January 1997.

[53] On that occasion an area of central necrosis was well established. It was appropriate for clinical debridement of the necrotic tissue. Dr Campbell stated he "nibbled" away at the necrotic area with some forceps and scissors.

This was done in his surgical operating theatre. The procedure was painless for Mrs Jaensch. There was no bleeding. There was routine packing of the wound. Dr Campbell stated he removed about four centimetres in diameter. It was an oval area of ischaemia or necrosis, just inferior to the nipple complex. The necrotic area involved the inferior part of the breast skin, but it also encroached on the peris-areolar suture line and part of the inferior aspect of the areolar. The lateral half of the suture line was involved.

[54] It is Dr Campbell's evidence that the wound did not break down. This was an observation that was written on the records of the hospital when Mrs Jaensch presented at the accident and emergency on New Years Day.

[55] Dr Campbell's evidence is that with a subcutaneous mastectomy there is a primary risk of necrosis particularly around the nipple and areola. It is an accepted risk of that procedure. It is accepted that there can even be a partial necrosis of the nipple. Other complications of this operation include bleeding, continued oozing or seroma formation and the possibility of infection. Dr Campbell stated these are the four complications that he discusses with patients contemplating a subcutaneous mastectomy.
Dr Campbell stated in his experience infection in breast wounds is not common.

[56] Dr Campbell stated that he told Mrs Jaensch that with the subcutaneous mastectomy, there was more risk of developing necrosis than a simple mastectomy. That there was a possibility of necrosis particularly around the

nipple area. He told her the complications of bleeding and seroma formation and that some people do get an infection. Dr Campbell states he told Mrs Jaensch that there was a risk with the operation of losing the nipple or some surrounding skin; because of the nature of the operation there would be a decreased blood supply to the central aspects of the breast wound. Mrs Jaensch had responded by basically saying; "when can we do the operation".

[57] Dr Campbell disputed Mrs Jaensch's statement that from the time she was discharged from Royal Darwin Hospital until the date early in January 1997 when Dr Campbell removed the necrotic tissue, there had been no consultation with Dr Campbell. It is Dr Campbell's evidence that he saw Mrs Jaensch on two occasions in December before Christmas the first was on 16 December, two days after she left hospital and the second was about a week later. On the second occasion Dr Campbell observed an established necrosis in the central aspect of the breast but the wound or area of ischaemia had not demarcated. It did not have a clear boundary of demarcation (t/p 148). Once this boundary has been established, it becomes a definite geographical line and that is the area where – there'll never be any further salvage of any tissue from that margin, where it can safely be debrided, minimising any loss of further skin.

[58] Dr Campbell stated when he saw Mrs Jaensch after her discharge from hospital his suspicions were confirmed. It was evident Mrs Jaensch would lose some tissue from her breast skin. Dr Campbell gave evidence he was

satisfied that at this time all measures had been performed to control the extent of the necrotic area. It was a matter of watching and waiting for the right time to debride.

[59] On 16 December 1997, Dr Campbell initiated intravenous Keflex antibiotics. Mrs Jaensch was maintained on an oral antibiotic treatment and daily dressings with the community nurse clinics. Dr Campbell states he told the nurses they should organise with the community nurse clinic to initiate daily dressing procedures following Mrs Jaensch's discharge from hospital and that he would catch up with his patient in his rooms at an organised date. Dr Campbell gave evidence he maintains documentary records of his clinical notes and that he kept such a record in respect of Mrs Jaensch.

[60] (t/p 151) Dr Campbell stated he saw Mrs Jaensch in his rooms early in the new year. This was a couple of weeks after the operation he had performed to debride the necrosis. This was the last occasion he saw her although he had requested she come back for another check up. Dr Campbell stated he was quite pleased with the progress of the debrided area, it had shrunk considerably and was looking quite clean and uncomplicated. Mrs Jaensch had an ulcer, which is just an area of granulating healthy tissue, and it was about a centimetre in diameter left to heal. It had made rapid progress since the debridement. Dr Campbell identified certain documents as his record of consultations with Mrs Jaensch commencing 17 November 1995. These were tendered and marked Exhibit D19. These records show the last times he saw Mrs Jaensch were 13 January 1997 and 28 January 1997. On

13 January 1997 he noted “much cleaner” and advised she return for a check-up in two weeks on 28 January 1997. On 28 January 1998, Dr Campbell noted there was a clear 1 cm ulcer and advised she return for a check-up in three months. Mrs Jaensch did not return.

[61] Dr Campbell was shown the four photographs (Exhibit P10) and stated he could not see any scarring in these photos. He could not see any part of a nipple or areola. He agreed he could see some pigmentation which appears to be enfolding in one of the creases and that he had the impression this was the margin of the areola skin being the superior part of the areola. With respect to photograph No. 4, Dr Campbell stated that what appears to be two areas of quite substantial creasing is the creasing due to the collapse of the original breast contour due to the elimination of the underlying breast tissue. This is a natural phenomenon in a subcutaneous mastectomy.

[62] Dr Campbell stated he could not see any scarring in these photos and stated there would be scarring which could be seen by parting the more central fold in the skin.

[63] (t/p 161) Under cross-examination Dr Campbell described the accounting record and form of invoice that he used in his practice, he described his appointment diary maintained by his secretary, his surgical operation record diaries and made reference to the medication sheets in the hospital records in which he prescribes medication. Dr Campbell was then referred to the Darwin Private Hospital notes (Exhibit P14) and in particular a document

titled: “To be completed by: Patient and Medical Practitioner”. This document is in two sections (i) consent which has been signed by Mrs Jaensch indicating she consents to the following operation “right subcutaneous mastectomy”. The section underneath that says (ii) Confirmation: providing for the name of the doctor and stating that he has explained to the patient the nature and effect of the operation and anaesthetics and that in the doctor’s opinion the patient has understood this explanation. This part of the document is not completed and has not been signed by Dr Campbell. Dr Campbell stated that he did warn Mrs Jaensch about the complications associated with the operation he was about to undertake and that to give such warnings was part of his training. He agreed he had not made a note of this on the document in Exhibit P14. He disagreed that he treated this flippantly and stated he knew that he was required to tell the patient the reasonable, foreseeable risks of an operative procedure. Dr Campbell did make reference to some patients who will never give up on asking about erratic and perhaps inappropriate complication risks.

[64] Mr Reeves QC cross-examined Dr Campbell extensively as to what it was Dr Campbell had said to his counsel, Mr Bruxner, about the warnings he had given Mrs Jaensch on 15 October 1996.

[65] The reason for the questions is that in his opening address for which Dr Campbell was not present, Mr Bruxner had stated (t/p 123):

> "He told her also about other risks inherent in the procedure, particularly in relation to what might develop afterwards. He told her that fluid would collect within the skin left of the breast, after the inner tissue had been removed. He told her there was a risk of haemorrhaging. He didn't tell her about infection; he didn't consider that that was a matter which needed to be brought to her attention. He did not warn of infection, except in circumstances where the location of the surgery was particularly prone to infection. "

[66] Mr Reeves QC particularly cross-examined Dr Campbell about the issue of infection because from Mr Bruxner's opening address it would appear his instructions were that no such warning had been given.

[67] Dr Campbell was either being deliberately difficult or extremely obtuse in his answers to Mr Reeves QC on the issue of what he had said to Mr Bruxner the week before the date he gave evidence. He finally conceded that he could not recall the details of his conversation with Mr Bruxner.

[68] Dr Campbell was then taken to his appointment diary and stated that he saw approximately 40 people on 15 October 1996, being the date of his interview with Mrs Jaensch. Mrs Jaensch was booked in at 2.30 pm. Dr Campbell saw Mrs Jaensch in May 1996 and on 15 October 1996. Dr Campbell stated that Mrs Jaensch was a peculiar case and he remembers her situation. He had taken over a lady with a serious problem breast cancer who needed ample supervision. As a witness, Dr Campbell could be described as his own worst enemy. I have set out the following exchanges with Mr Reeves QC as examples (t/p 176):

> "Can you remember precisely what happened at the – or in detail what happened at the conversation in May 1996?---I've a fair idea.

Can you remember now, in detail, what happened, what she said to you, what you said to her?---I haven't got a transcript of that one either, I'm sorry.

No. And you can't recall the detail of the conversation you had with her in May 1996, that's so is it?---Whatever you reckon.

No more – you agree with that, don't you?---Yes, sir.

No more than you can recall the detail of the conversation that occurred on 15 October 1996?---Whatever you reckon.

You agree don't you?---Yes."

At t/p 177 in reply to the question from Mr Reeves QC:

"You don't recall how long the conversation took?---Well, you're being pedantic you know ….."

At t/p 179 – 180:

"And what do you base that recollection on, your memory or records?---Some deep soul-searching into the situation at the time.

And when did you do that deep soul-searching?---A few days ago.

A few days ago. So you were thinking back 4 and half years a few days ago and recalled that you didn't see her on 15 December; is that right?---I don't know.

You don't know?---I don't know.

You just don't have a clue what happened on 15 December' is that so?---I wouldn't say that.

Well - - -?---I – I'm sure I was alert and responsible during the day.

Do you think you saw her on 15 December or not?---Well, you have the records, you have to tell me."

[69] Dr Campbell was asked about certain answers to interrogatories sworn on 16 June 2000 and gave the following evidence in cross-examination (t/p 181):

"Do you remember being asked a question: 'Please specify each date that you attended the plaintiff after 9 December 1996 while she was a patient at Darwin Private Hospital'?---And what did I say?

Do you remember being asked that question?---Yes.

You do?---Well - - -

Do you remember what the answer was?---I would have looked at the hospital record notes - - -

Do you remember what answer you gave?---Yeah, the answer would have been what I found in the notes.

No no, doctor, please, do you remember now what the answer was?---No, you tell me.

You don't? Do you remember – I'll read out the answer you gave: 'Daily from 10 December 1996 to 15 December 1996', remember saying that?---Yeah, I'd accept that.

So that's wrong, at least in relation to 15 December?---What date did she leave?

I beg your pardon?---She left on the 15th? If she left on the 15th, I don't believe I saw her.

No, but it's wrong to say that you saw her daily from 10 to 15 December?---Okay, you're right. Yes, I'm wrong.

Is that right? So 11 months ago, you made a mistake about what happened on 15 December; is that right?---You know - - -

Or is it that you just can't recall now what happened in relation to your attendances on her on 15 December?---I can tell you I was vigilant in my observation of the patient in the post-operative period. That's all I can tell you."

and at t/p 182:

"Well, do you remember being asked this question, 'In respect of the plaintiff's discharge on or about 16 December 1996, please state what directions were provided by you to the plaintiff in respect of post-operative care of the wound and how those directions where conveyed to the plaintiff'. Remember that?---Instructions were to maintain an occlusive dressing to the – the breast and to have community nurse supervision.

Do you remember saying – do you remember the answer you gave to that question?---No, you'll have to help me.

Do you remember being asked the question, firstly?---There's a vague recollection, yes.

And do you remember saying: 'When the plaintiff was discharged on 15 December 1996, I prescribed oral Keflex'? Remember saying that?---Yes.

So did you see her on 15 December 1996?---Not necessarily.

So is that inaccurate in that it suggests that you prescribed oral Keflex when she was discharged on 15 December?---I can still prescribe medication via different routes, you see.

Wouldn't a full and frank answer to that question have been: 'I did not see the plaintiff when she was discharged on 15 or 16 December 1996 but I had either previously or subsequently prescribed oral Keflex'? Wouldn't that be a full and frank answer?---Sounds good.

Is that what happened? Or can't you remember?---It's a bit vague."

[70] Dr Campbell was asked about Dr Selva attending Mrs Jaensch in hospital as Dr Selva had been involved with her treatment in the past. Dr Campbell stated he could not recall if Dr Selva did attend upon Mrs Jaensch at the hospital between 9 and 15 December or after she was discharged from hospital. However, he stated Dr Selva did have an entitlement to see Mrs Jaensch because of his previous involvement in her treatment.

[71] Dr Campbell stated he cannot remember details of the exact conversation with Mrs Jaensch at the time she was to be discharged from hospital. He does state he did give instructions about post operative care to Mrs Jaensch. After repeatedly being asked if he could recall the conversation he had with Mrs Jaensch at the time of her discharge, Dr Campbell gave evidence that at the time of her discharge he told Mrs Jaensch that her wound was in an undeclared state. However, the process of evolution of this inflamed or ischaemic area was still a long way ahead and she would need continued observation and "I will make arrangements to see you in my office at a later date. You need to keep the wound covered, stop it drying out and if there are problems, the community nurse clinic's sisters will attend to your

dressings and replace as necessary." Dr Campbell stated that at that time Mrs Jaensch did not require any post operative surgical care. On 15 December 1996 when Mrs Jaensch was discharged, Dr Campbell prescribed oral Keflex.

[72] Dr Campbell stated in evidence that at the time of Mrs Jaensch's discharge from hospital he arranged for community nurses to attend upon her. He agreed he had not mentioned this in his answers to interrogatories.

[73] Dr Campbell agreed under cross-examination that there was no mention in the answer to interrogatory No. 14 (Exhibit D18) in the Darwin Private Hospital notes (Exhibit P14), or in his own notes (Exhibit P19), that he had arranged for community nurses to see her after her discharge. He agreed it was an important aspect of her post operative treatment that she was to be attended regularly and frequently by community nurses. Dr Campbell said that he did not document everything.

[74] Dr Campbell then gave the following evidence in cross-examination (t/p 199):

> "And yet there's no note anywhere in your record system of this important aspect of her post-operative care, is there?---Doesn't appear to be.
>
> Because I suggest it didn't happen, doctor?---If it didn't happen, did it influence the patient's subsequent course of events, I doubt it.
>
> I'm suggesting to you, doctor, that what really happened was that you arranged for the community nurses to attend on her regularly and frequently, after you saw her on 6 December – 6 January 1997, that's what happened wasn't it---Okay, fair enough.

> So the community nurses weren't involved until about three weeks or more after her discharge from hospital, that's what happened?---Well, you have two Community Health Centre notes on that particular point.
>
> I'm asking you to accept that is what – that you're confused about when the community nurses were involved, and it was in fact after your attendance with her on 6 January that the community nurses became involved, would you accept that?---No, not entirely."

[75] Dr Campbell agreed he had made no note of any warning he gave to Mrs Jaensch about necrosis or infection or bleeding or fluid retention. He stated that there is no way he would have omitted telling Mrs Jaensch of the possibility of complications following a subcutaneous mastectomy because (t/p 200) "… it's inculcated into my program of speech to educate a patient about an operation …". He agreed he did not sign the confirmation form on the Darwin Private Hospital file (Exhibit P14).

[76] Dr Campbell agreed that in a letter dated 22 October 1996 to Dr Selva (Exhibit P20) he had not made mention of any warnings he had given to Mrs Jaensch. He agreed there was no contemporaneous record of having given Mrs Jaensch any warning associated with the surgery she was about to undertake on 9 December 1996.

[77] He agreed that following her discharge on 16 December good practise required that the patient's wounds be observed closely.

[78] The hospital notes record that on 14 December, Mrs Jaensch's wound was hot and red and inflamed. Dr Campbell agreed these were signs that would alert him to the need to look out for infection. At the time of her discharge

she had signs indicating the possibility of infection and necrosis.

Dr Campbell stated he could not recall if he made any arrangement for Mrs Jaensch to be observed on a daily basis.

[79] Dr Campbell stated he could not accept that he was negligent, he had made arrangements to see the patient again and she had been told if there were any problems to contact him straight away.

[80] Dr Campbell saw her again on 23 December. He was asked about a note made as to Mrs Jaensch's condition on 16 December 1996 and gave the following evidence (t/p 208 – 209):

> "MR REEVES: When did you write the note?---Well, as far as I – my notes would tell me, it was on 16 December.
>
> No, no, can you recall when you wrote the note?---No more than you can recall what you were doing on 16 December 1996.
>
> No, but I'm not claiming to remember what happened 4 and a half years ago, doctor, you are, aren't you – or are you not?---Okay, I can't remember.
>
> You can't remember, you can't remember these events of December 1996, can you?---I tell you what. I've got a fair idea what was going on at the time.
>
> You can't remember these events of 1996 in relation to Mrs Jaensch can you?---I can't remember what clothes I had on the day.
>
> No?---But I can - - -
>
> No, or what she said?---I remember seeing the patient on several occasions.
>
> Yes?---And following up her post-operative care.
>
> And that's about the level of your recollection of your dealings with her at that time, isn't it?---Yes."

[81] (t/p 210) Mr Reeves QC referred Dr Campbell to a letter (Exhibit P21) he had written to Dr Selva on 24 December 1996. Dr Campbell agreed there

was no mention in this letter of any observations being conducted on Mrs Jaensch's wound after 16 December 1996. Nor any mention of the community nursing service being involved in her treatment. Nor is there any mention of Dr Campbell's attendance upon Mrs Jaensch on 23 December 1996.

[82] Dr Campbell agreed that he did not treat Mrs Jaensch between 24 December and 6 January and did not make any observations of her in that period. Dr Campbell then gave this evidence (t/p 212):

> "And you didn't arrange for the community nurses to do that, do you?---If that's what you say.
>
> Well, I'm putting it to you as a fact. Do you accept that?---If – I tell you what. If it's not indicated to have a daily visit by the community nurses, it wouldn't have been arranged. Now we're not going to waste their time going to say hello to a patient.
>
> But the indications were plainly there for her to be observed – that is for her wound to be observed – during all of this period, weren't they?---By self-observation and for immediate contact with the surgeon if there were any doubts or worries."

[83] Dr Campbell stated he operated on 2 January 1997. There is no record of any appointments in his diaries on 4 and 5 January. Dr Campbell agreed there was no note of his giving Mrs Jaensch any treatment or observing her between 24 December and 6 January.

[84] On 6 January, Dr Campbell undertook a debridement of the wound. Following the debridement Dr Campbell wrote a note to the Community Nursing Service asking them to attend to Mrs Jaensch. Progress notes for the Community Nursing Service of Territory Health Services relating to

Mrs Jaensch indicate that she was attended to by community nurses from 7 January to 7 February 1997.

[85] An undated letter to the Community Nursing Service was tendered Exhibit P22. It would appear this letter was written on 6 January 1997 as Dr Campbell states “I have debrided it to-day”. He asks in the letter for community nurses to “redress the wound on a daily basis”. The progress notes and flow chart from the Community Nursing Service dated January 1997 is Exhibit P23. This details attendances by community nurses on Mrs Jaensch between 7 January 1997 and 7 February 1997.

[86] Dr Campbell under cross-examination accepted that his evidence that he had involved Community Nursing Service in Mrs Jaensch’s treatment in December 1996 was not accurate. He added that this did not influence the course of the evolution of the problems with her right breast.

[87] In re-examination, Dr Campbell stated that inflammation is not necessarily a sign of infection but can be part of the evolution where the skin flaps become pale and then dusky and then black. Inflammation could also be related to trauma , the redness is due to the concentration of blood in that area. Dr Campbell stated any surgical trauma or incision leads to swelling and congestion. An incision line will always become swollen, and under tension in that period, it often becomes a little more pinkish in that intervening period.

[88] There is no dispute between the parties that Dr Campbell was under a duty to warn Mrs Jaensch as to the possible side effects of the subcutaneous mastectomy.

> " a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attack significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it. …"

*Rogers v Whitaker* (1992) 175 CLR 479 at 490.

[89] Essentially in this case, Dr Campbell had a duty to warn Mrs Jaensch about the possibility of necrosis, fluid retention, haemorrhaging and infection.

[90] The plaintiff, Mrs Jaensch, claims that there was no warning given to her of the risks of the operation and that she was in fact given a positive assurance that there would be no complications.

[91] Secondly, Mrs Jaensch claims that the post operative treatment under the care of Dr Campbell fell short of the competence required in the circumstances, in particular, the required care between 23 December 1996 and 6 January 1997 was not to a satisfactory standard.

[92] (t/p 246) Mr Bruxner, counsel for the defendant, submitted that in her evidence Mrs Jaensch was adamant that her surgical wound was only looked at twice whilst she was in hospital between 9 to 16 December 1996 and that Dr Campbell did not see her on either 16 or 23 December 1996.

[93] It is Mr Bruxner's submission that the hospital records (Exhibit P14) include a number of references to Mrs Jaensch having been visited regularly to have her wound inspected.

[94] I agree that an examination of the Darwin Private Hospital's records including the nursing progress notes, indicate that Mrs Jaensch was kept under close observation and her wound checked at least daily whilst she was in hospital.

[95] The record cards of Dr Campbell were tendered Exhibit D19 and these indicate Dr Campbell attended upon Mrs Jaensch on 16 and 23 December 1996. It was not put to Dr Campbell in cross-examination that these attendances did not occur.

[96] I am not able to accept the evidence given by Mrs Jaensch that her wound was only looked at twice whilst she was in hospital. Nor can I accept her evidence that she was not attended to by Dr Campbell on 16 and 23 December 1996.

[97] Mrs Jaensch may quite genuinely believe that what she has stated in her evidence about this lack of attention is factual, however, I am not able to make such a finding and have concluded that in reconstructing events at a later time Mrs Jaensch's recollection is not reliable.

[98] The plaintiff's case rests in respect of the first aspect of her claim on allegations that the defendant failed to warn the plaintiff of the risks

associated with the operation; being the subcutaneous mastectomy.

Mrs Jaensch has given evidence that Dr Campbell did not explain to her the difference between a simple mastectomy and a subcutaneous mastectomy. It is her evidence that Dr Campbell did not explain any of the procedures, that the operation could cause problems with blood supply to the breast skin and that this could lead to some dying of the skin. She stated Dr Campbell had not explained there could be haemorrhaging or the possible need to drain fluid which may collect in her breast.

[99] It is Mrs Jaensch's evidence that Dr Campbell did not explain that if she wanted to have a breast reconstruction then there would be a cosmetically better result if the nipple were retained. Mrs Jaensch also gave evidence to the effect that when she underwent the subcutaneous mastectomy she was aware the right nipple was to be retained but did not know how this would be achieved. Mrs Jaensch stated she has not consulted with a doctor about reconstruction of her right breast but it is something she would consider doing in the future.

[100] Mrs Jaensch has given evidence that her right nipple was totally lost when Dr Campbell removed the dead skin in the area of her right areola on 6 January 1999. She is supported in this by the evidence of her daughter, Erika Tatiana Jaensch, who gave evidence that she was present at the debridement on 6 January 1997. Dr Campbell was not asked and did not give evidence to the effect that it had been necessary to totally remove the right nipple. My recollection of the view does not support a finding that the

right nipple has been completely removed. The photographs, Exhibit P10, show a significant folding of the skin including the area of the right nipple. However, photographs 1, 2 and 4 show what appears to be part of the areola tucked into the fold of the skin. None of the expert medical witnesses called to give evidence in this matter had physically examined Mrs Jaensch. Their opinions were based on medical records, the claim as stated in the writ and the photos (Exhibit P10). Dr Campbell's evidence is to the effect that the area of the right breast that was debrided was inferior to the nipple and involved a relatively small area.

[101] Mrs Jaensch states that Dr Campbell did not warn her about the risk of infection. She had been informed she states that she would be in hospital for three days instead she remained in hospital for seven days.

[102] Dr Campbell was cross-examined at some length about his failure to warn Mrs Jaensch about the possible consequence of the operation. In particular his failure to warn her that it may be necessary to subsequently debride some dead skin tissue.

[103] Dr Campbell was a most unsatisfactory witness, as I think some of the examples of his answers in cross-examination will demonstrate. However, I do not consider him to be a dishonest witness. Dr Campbell stated he does not recall the exact details of his conversation with Mrs Jaensch in May and October 1996. After sifting through some of the rather silly and fatuous replies made by Dr Campbell, his evidence is to the effect that although he

does not remember the detail of the conversation, he does have a clear memory of Mrs Jaensch as a woman with a severe problem. Dr Campbell's evidence is to the effect that although not able to recall the exact words that were used, that he did in fact discuss the difference between a simple mastectomy and a subcutaneous mastectomy. That he obtained Mrs Jaensch's consent to proceed with a subcutaneous mastectomy because this would allow for future reconstruction of her right breast. That he did warn her of the possibility of ischaemia and necrosis and the problems that could arise if there was a lack of blood supply to the skin.

[104] I do not accept the evidence given by Mrs Jaensch that Dr Campbell told her the operation which would enable her to retain the nipple of her right breast would not involve any complications. I do not consider Mrs Jaensch's memory of her conversations with Dr Campbell or the details of her numerous attendances upon him is reliable. One example is her own evidence that she had no memory of seeing Dr Campbell on 16 and 23 December 1996 when clearly these attendances did occur. I prefer the evidence of Dr Campbell that he did in fact give Mrs Jaensch the requisite warnings about the possible complications of a subcutaneous mastectomy.

[105] The Darwin Private Hospital notes (Exhibit P14) contain a form of consent to a right subcutaneous mastectomy signed by Mrs Jaensch and witnessed by Dr Campbell on 15 October 1996. The form of consent signed by Mrs Jaensch also contains the words "the nature and effect of the above operation(s) has been explained to me by Dr Campbell." The second part of

the document being the confirmation that Dr Campbell had explained to her the nature and consequences of the operation and that she understood the explanation had not been completed and signed by Dr Campbell.

[106] Nevertheless, I am satisfied that Dr Campbell did explain the full consequence of the operation to Mrs Jaensch and warned her of the possible complications.

[107] I have referred to the reports from Professor Gough. I accept the evidence of Professor Gough that Dr Campbell performed the operation competently. I also accept the evidence contained in his report that the loss of skin tissue caused by ischaemia is a known complication of this type of surgery.

[108] I formed the impression that when Mrs Jaensch consulted Dr Campbell she had decided to have an operation to her right breast and that nothing was going to dissuade her from this course. The reason for Mrs Jaensch's determination to effect removal of her right breast was her fear that she could be subjected to the unfortunate experience she had undergone when she claimed that a delayed diagnosis of cancer in her left breast had very serious consequences.

[109] None of the doctors called to give expert evidence in this matter had in fact physically examined Mrs Jaensch.

[110] Dr McLaren is a registered specialist in psychiatry and is in general practice. I accept the evidence of Dr McLaren that Mrs Jaensch does not

suffer any form of mental illness. I also accept his opinion that she does show a persisting and intense fear of the medical profession in general which is reality based, it is not a neurotic fear. Nor could this fear be described as phobic. Whilst photos of Mrs Jaensch and the view undertaken by the Court show an apparent deformity to her right breast because of the folds of the skin, I do not accept the evidence of Dr McLaren that there is gross scarring. I prefer the evidence of Dr Gill who states in his report (Exhibit D27) that he presumes the nipple is "indrawn in the central puckered area and there is clearly a lot of redundant skin present with minimal evidence of a surgical scar". In the opinion of Dr Gill, the changes seen are quite consistent with the removal of breast tissue without any form of immediate reconstruction. Dr Gill considered that reconstruction of Mrs Jaensch's right breast could be achieved. I accept the evidence of Dr Gill and Professor Gough that the operation was competently performed and reconstruction of the right breast could be achieved.

[111] The tenor of Dr Gill's report (Exhibit D27) is that the operation was performed satisfactorily and that Dr Campbell took appropriate steps to prevent the development of necrosis and treat it once it had developed.

[112] This opinion is supported by Professor Gough who stated in his report (Exhibit D25):

> "In my opinion the right subcutaneous mastectomy was a reasonable operation and it was performed competently by Dr Campbell. The loss of a small amount of skin is a well recognised and not uncommon complication of this surgery. The cosmetic appearance is

> within the range of reasonable expectation considering the deliberately preserved skin, the patient's body size and shape and the breast size and shape. If a simple mastectomy removing the nipple and more of the skin had been performed, the cosmetic appearance may have been somewhat better but the subcutaneous mastectomy was specifically done because of the patient's preference for preserving the option of future reconstruction. In my opinion Dr Campbell's management of the patient met the required standard of care."

[113] Dr Scott gave a considerable amount of evidence concerning the complications that can arise from a subcutaneous mastectomy and the ideal methods of treatment in situations where such complications arise. His report dated 31 March 2001 (Exhibit P13) answers a number of specific questions and states that by 23 December 1996 there was evidence of impaired blood supply and infection. He then detailed the appropriate treatment which he considered should include debridement. Debridement was in fact carried out by Dr Campbell on 6 January 1997.

[114] Dr Gibson is also of the opinion that active surgical treatment should have been instituted on 23 December. In his report dated 22 March 2001 (Exhibit P16) Dr Gibson concludes:

> "If more timely surgical action had been taken when necrosis was established, subsequent scarring probably would have been reduced."

[115] Dr Gibson is also of the opinion that there appears to be enough skin left for reconstruction of the right breast. In his report dated 4 July 2000 (Exhibit P15) he states:

> "The scarring and skin distortion on the right side is greater than one would expect after a successful subcutaneous mastectomy without complications."

[116] I have accepted the evidence of Dr Campbell that he did advise Mrs Jaensch of the difference between a simple mastectomy and a subcutaneous mastectomy. I also accept Dr Campbell's evidence that he did advise Mrs Jaensch of the complications that can arise from a subcutaneous mastectomy. Dr Campbell failed to complete the confirmation section in the Patient's Consent Form (Exhibit P14) which is clearly not a good practice but does not in itself amount to negligence. Nor does it confirm that he failed to provide the warnings. Mr Reeves QC, counsel for the plaintiff, points to the fact that there is no contemporaneous record of any warning having been given either in Dr Campbell's own notes or in correspondence he had with Dr Selva. Whilst such contemporaneous record would support Dr Campbell's statement that he did give the requisite warnings, I would not necessarily expect to see a reference to such warnings either in his own notes or in the correspondence with Dr Selva. The notes prepared by Dr Campbell and his letters to Dr Selva were for the purpose of conveying and recording necessary information. They were not prepared with the intention of covering every facet of Dr Campbell's treatment of Mrs Jaensch.

[117] On the evidence before me, the plaintiff has not satisfied me on the balance of probabilities that Dr Campbell failed to adequately warn her of the

possible consequences of the surgery to effect a subcutaneous mastectomy. Accordingly, this aspect of her claim must fail.

[118] The second claim in negligence is that the post operative treatment fell short of the requisite standard of care.

[119] A doctor is required to exercise reasonable care and skill in the provisions of medical treatment and advice (*Rogers v Whitaker* (supra)). This also includes post operative care (Laws of Australia Electronic Ed Chapter 27 Professional Liability).

[120] It is the submission of Mr Reeves QC, counsel for the plaintiff, that knowing that the signs of infection were present; the redness, the soreness of the wound, observing discolouration of the skin and therefore knowing that the signs of necrosis developing were present on 16 December and the signs of infection were present, up to and including 14 December, Dr Campbell was plainly negligent in not keeping the plaintiff under observation in the three weeks between then and when he did something about her condition.

[121] I accept Mrs Jaensch had necrosis. There is no evidence of necrotising infection. Dr Campbell is adamant there was no necrotising infection and I accept his evidence on this aspect. Skin was removed without anaesthetic and there is no complaint from Mrs Jaensch that she suffered pain during the removal of the dead tissue when her right breast was debrided by Dr Campbell on 6 January 1997. The wound itself had healed properly. There was some evidence that the wound was infected. Indeed Dr Campbell

prescribed antibiotics. However, there is no evidence of infectious necrosis. Professor Gough stated there was no evidence of necrotising infection and I accept this evidence

[122] None of the five medical experts who gave evidence in these proceedings, being Dr McLaren, Dr Scott, Dr Gibson, Professor Gough and Dr Gill, had physically examined Mrs Jaensch before giving evidence. They were each provided with reports, medical reports and other documentary material.

**Evidence of Dr Scott**

[123] Dr Scott is a senior consultant at the Royal Melbourne Hospital practicing in general, traumatic and breast surgery.

[124] Dr Scott gave evidence that by 23 December 1996 there was evidence of impaired blood supply and infection in his report dated 31 March 2001 (Exhibit P13). He went on to state that:

> "… by 23rd December 1996 there was evidence of ischaemia and this would have required debridement, swab and microscopy and sensitivity tests and administration of the appropriate antibiotics."

[125] Dr Scott gave evidence in the following terms: Where ischaemia presents on the skin, the ultimate extent of the necrosis which may result, is not going to be immediately apparent. Ischaemia does not necessarily lead to necrosis. It depends on the degree of the ischaemia, the number of blood vessels involved and the circulation in this case through the skin. Necrosis will

only occur if the ischaemia is severe enough to severely deprive skin of nutrition. Demarcation is the term given to the point where the dead skin ends and the living tissue begins. It is not until the point that there is demarcation that it can be known whether skin potentially affected by ischaemia is in fact going to be affected by necrosis. If the doctor intervenes before demarcation has been established, the doctor may take either more skin than is needed or not enough. Until demarcation takes place it is not known how extensive the necrosis is going to be.

[126] Once necrosis has declared itself, the dead tissue either falls away or can be easily separated from the surviving tissue. Once the necrotic skin and/or tissue has been removed, what is left is an ulcer. An ulcer is a deep rift to the skin. Dr Scott agreed that in the case of an ulcer on the skin flap of a breast, having undergone a subcutaneous mastectomy, that ulcer may well attach to the outer chest wall.

**Evidence of Dr Gibson**

[127] Dr Gibson has been a Fellow of the Royal Australian College of Surgeons for about 25 years.

[128] Evidence was given by Dr Gibson as follows: The subcutaneous mastectomy has a higher risk of the patient developing necrosis as distinct from simple mastectomy. Necrosis is very rare in a simple mastectomy. Necrosis is an accepted complication of subcutaneous mastectomy, anticipated and hopefully avoided. Dr Gibson agreed that because of the removal of the

breast tissue, the blood supply to the nipple and surrounding area is reduced. He also agreed this means that there is a risk of necrosis developing post operatively due to insufficient blood supply. Dr Gibson stated that the patient should be observed daily for the first four or five days. The note of the attendance by Dr Selva on 14 December 1996 referred to inflammation and redness. The redness would indicate infection and the change in colour would indicate a necrosis. With these signs the patient should be monitored daily. In addition to this the patient should probably be started on antibiotics if there was a suspicion of infection. It should be ensured there was no collection of fluid under the skin like blood or serum. If necrosis is threatened the dead tissue should be removed, consideration given to repair by either skin grafts at the time or a secondary suture of the skin. Prevention should be early. If the necrosis is a fairly small area then maybe it would be appropriate to wait and see. If the necrosis involved the nipple, then intervention should be early.

[129] Dr Gibson was taken to his report which referred to an attendance on 16 December 1996 where some changing colour was noted. The next record of her having been seen by a medical person was when Dr Campbell attended upon her on 23 December 1996. The following attendance by Dr Campbell was 6 January 1997. It is Dr Gibson's evidence that given the signs noted on 14 and 16 December 1996, Mrs Jaensch should have been observed daily. Dr Gibson did not agree with Dr Campbell's statement that necrosis can take weeks to manifest. It is Dr Gibson's evidence that if the

area of necrosis is only small, then it is reasonable to just excise the dead skin. If there is more rapid skin necrosis then there should be a more radical approach which involves cutting into living tissue.

[130] Under cross-examination, Dr Gibson agreed that one of the main symptoms of necrosis which is independent of infection is ischaemia or reduced blood supply. This can lead to necrosis because the skin is deprived of oxygen and dies. One of the signs of ischaemia is a change in the skin colour to blue (t/p 104).

[131] Dr Gibson went on to state that demarcation is the term used for the point at which necrosis has declared itself. When that point is reached it is known which skin will survive and which skin will not. Until this point is reached it cannot be known for certain just how much skin is going to be lost. It can occur where ischaemia has been evident, the area has been observed and necrosis, in fact, has not developed. Dr Gibson agreed that as a general statement that in cases of necrosis not involving necrotising infection that until necrosis has declared itself then surgical intervention is premature or potentially premature. Dr Gibson also agreed that in cases where the purpose of the subcutaneous mastectomy is so that the patient can subsequently, if she chooses, undergo a reconstruction, one of the factors that would be relevant in that situation is retaining as much skin as possible and the nipple. Dr Gibson gave evidence that he is familiar with healing by a process of secondary intention. When an ulcer heals in that way a scar is left behind. The scar contracts, scar tissues forms as part of the healing

process and as the ulcer heals the area can become hitched to the chest wall. The area of attachment can be detached for the purpose of inserting the prosthesis. However, if the nipple is lost that is a difficult thing to do. If there is a necrotising infection there should be a strong antibiotic regime, you would remove dead tissue but would be wary about removal of further tissue from the area.

[132] Dr Gibson stated he had not physically examined Mrs Jaensch. He did have with him at the time of cross-examination, a photocopy of some photographs of Mrs Jaensch. Dr Gibson agreed that in addition to the photographs, the information provided to him was that Mrs Jaensch had lost her right nipple. It is Dr Gibson's evidence that the photographs show scarring, with some folding of the skin. He further observed that there is not mid excess skin. At t/p 112 Dr Gibson gave the following evidence in cross-examination:

> "Allright. But if the evidence is that the only skin removed was a area of 3 or 4 centimetres from just near the nipple, then whatever appears over towards the arm isn't related to the removal of that skin?---That's correct, yes."

[133] In re-examination, Dr Gibson was referred again to the photographs of Mrs Jaensch. It is his evidence that there is a lot of distortion with the loss of three or four centimetres of skin and there appears to be less surface skin than he would expect from a subcutaneous mastectomy.

[134] Dr Gibson was referred to his report dated 4 July 2000 (Exhibit P15) and stated that he had the photographs of Mrs Jaensch when he answered the two questions put to him and answered in his report (p 5):

> "In record to two queries of 03.07.00 I comment as follows:
>
> 1. The scarring and skin distortion on the right side is greater than one would expect after a successful subcutaneous mastectomy without complications.
> 2. The scarring should not make difficulties in reconstruction provided there is enough skin remaining for reconstruction."

[135] Dr Gibson was asked what is likely to happen if you leave a wound without treatment after demarcation has occurred. Dr Gibson replied that ultimately the skin would be rejected by the body. If it takes weeks to heal there will be more scar development and more scar contraction and distortion. In addition the patient has the discomfort of having their wounds dressed over a period of weeks and a large unhealed area of skin.

[136] The plaintiff tendered the outpatients records of the Darwin Private Hospital (Exhibit P17).

[137] Also tendered was question and answer in "Consolidated Interrogatories and Defendants Answer to Interrogatory 14" (Exhibit P18) which reads as follows:

> "Q14. In respect of the Plaintiff's discharge on or about 16 December 1996 please state what directions were provided by you to the Plaintiff in respect of post operative care of the wound and how those directions were conveyed to the Plaintiff.
>
> A14. When the Plaintiff was discharged on 15 December 1996 I prescribed oral Keflex. I cannot now recall the conversation

> that I had with the Plaintiff but my standard procedure in such circumstances is to advise the patient to come and see me in a week's time, or earlier if there are any changes. The wound did not require any post-operative care other than to keep the dressing on and replace it as necessary, for example if it became too wet."

**Evidence of Professor Gough**

[138] Professor Gough gave evidence he has appointments as a visiting surgeon to the Royal Brisbane Hospital and as a clinical professor of surgery at the University of Queensland. The curriculum vitae for Professor Gough is Exhibit D24. A report from Professor Gough concerning Dr Campbell's treatment of Mrs Jaensch dated 30 June 2000 was tendered Exhibit D25. A second report dated 17 April 2001 is Exhibit D26.

[139] The final two paragraphs of his report dated 17 April 2001 (Exhibit D26) reads as follows:

> "It is obvious that none of the commentators are in a position to know the exact details of the patient's situation at that time because we are all relying on the written records. However, it appears to me that ischaemia was more important than infection.
>
> In my opinion, ischaemia was the main cause of the loss of tissue and scarring. This is a known complication of this type of surgery. The area of necrosis declared itself by demarcating from the surrounding viable tissue. Earlier debridement would probably not have resulted in less scarring and deformity and Dr Campbell's post operative management was reasonable."

[140] Under cross-examination Professor Gough stated that in forming his opinions he had been provided with a copy of the writ, a copy of Dr Campbell's records, letters written by Dr Campbell, four photographs of

Mrs Jaensch, the records from Darwin Private Hospital relating to Mrs Jaensch and a three page document with a chronology of Dr Campbell's responses.

[141] Professor Gough stated that he inferred from the fact that Dr Campbell prescribed antibiotics that a wound infection was developing at the Darwin Private Hospital. This was a reference to a contact with Dr Campbell on 12 December 1996 when Keflex was prescribed. There was also reference to the insertion of a drain on 12 December 1996.

[142] Professor Gough agreed he did not have the page of the notes dated 14 December 1996 in which appeared the following reference "wound remains painful and inflamed".

[143] Professor Gough agreed that there is no suggestion in Dr Campbell's letter dated 24 December or in the writ a suggestion that Mrs Jaensch personally requested a right subcutaneous mastectomy.

[144] Professor Gough stated that he based his opinion that Dr Campbell performed the operation competently on the notes prepared by Dr Campbell and on the subsequent course of events which were described as unexceptional.

[145] Professor Gough agreed that the correct technique would be to observe the wound while waiting for the demarcation to occur. If there was evidence of ischaemia these observations would be made frequently.

[146] Professor Gough said from the notes that were taken there was no evidence of necrotising infection.

[147] (t/p 238) It is the evidence of Professor Gough that the main difference between a simple mastectomy and a subcutaneous mastectomy is the preservation of the nipple. From the plaintiff's own words in the writ Professor Gough said it is clear that she wished to preserve the nipple of her right breast. Professor Gough also made reference to a letter dated 22 October in which Dr Campbell comments that after the subcutaneous mastectomy Mrs Jaensch was going to consider reconstruction.

**Evidence of Dr Gill**

[148] A report of Dr Peter Gill dated 10 July 2000 and his curriculum vitae were tendered and marked Exhibit D27. Paragraph (e) of that report reads as follows:

> "*In your view, did Mr Campbell take appropriate steps to prevent the development of necrosis and to treat it once it had developed?*
>
> The records indicate that Mrs Jaensch was retained in hospital for a week following her surgery and that her wound was inspected the day after surgery and the dressings changed and that she placed on Keflin 1g six hourly intravenously on 10/12/96 the day after operation when it was I think suspected that there may have been some infection present. This was an appropriate course of action and apart from cleansing the wound and treating any obvious infection, no other measures would be appropriate. There was no record at that stage that there was any impending necrosis which may have been evident by discolouration of the skin or extreme pallor and mottling, in which case, the use of Dextran to improve microcirculation and anticoagulants can minimise subsequent necrosis. However, there was no evidence that such was impending at that time. She was subsequently seen in the emergency department following her

> discharge from hospital and she was given broadspectrum antibiotics with an anaerobic cover and it was noted that established skin necrosis was present although the exact dimensions were not stated. Subsequently she was seen by Dr Campbell in his rooms and the necrotic skin was trimmed and a dressing applied with subsequent satisfactory healing. I think the implication of this is that the area of necrosis was small and that normally excision of the dead tissue with healing by what we call secondary intention would be quite appropriate.

Dr Gill was not cross-examined.

[149] The argument for the plaintiff is that in the three weeks between the signs of infection and necrosis developing on 16 December and 6 January 1997 when Dr Campbell debrided the wound he saw her on one occasion being 23 December 1996. Mr Reeves QC points to the evidence that supports a finding that in this period Dr Campbell made no arrangements to have Mrs Jaensch observed and treated post operatively.

[150] The plaintiff's claim is that the defendant was negligent because he did not make the necessary arrangements for either himself or someone else to keep her under observation. There was some evidence to the effect that Dr Campbell himself would be away or unavailable for a period of time after 23 December 1996. The plaintiff further claims that as a consequence of the delay in carrying out the debridement of the skin of her right breast, there was additional scarring, pain, suffering and discomfort.

[151] It is the submission on behalf of the plaintiff that it was simply not a good enough standard of care for Dr Campbell to tell Mrs Jaensch on 23 December to come back and see him again without making more specific

arrangements for her to be kept under close observation. Dr Gibson said Mrs Jaensch should have been observed daily. Dr Campbell himself made reference to the necessity to keep a person with developing necrosis under close observation.

[152] (t/p 277) The submission on behalf of the plaintiff is that Dr Campbell in his evidence ultimately conceded that on 16 December he had not arranged for community nurses to attend to Mrs Jaensch. This arrangement was not made until 6 January 1997 when Mrs Jaensch attended Dr Campbell in his rooms and Dr Campbell removed some of the skin tissue from her right breast as a consequence of the necrosis. There is no note in the hospital records or Dr Campbell's own notes that he made arrangements in respect of the community nurses on 16 December 1996. In Dr Campbell's answer to interrogatory No. 14 (Exhibit P18) there is no mention of arranging for community nurses to attend upon Mrs Jaensch. I accept the submission made on behalf of the plaintiff that the appropriate finding on the evidence is that:

a) the community nurses were not involved until after the treatment on 6 January 1997; and

b) that Dr Campbell's recollection about that aspect of her post operative treatment is not reliable.

[153] I accept the submission that on the evidence given by Dr Campbell he was wrong when he answered interrogatory No. 14 (Exhibit P18) to the effect that he saw Mrs Jaensch on 15 December 1996.

[154] I also accept that by 16 December 1996 there were signs present indicating the presence of infection and/or necrosis in Mrs Jaensch's right breast. It was important that Mrs Jaensch be kept under constant observation. Dr Campbell did not make any arrangement at that time for her close observation.

[155] I have concluded that the failure to have Mrs Jaensch kept under close observation in view of the signs of necrosis and/or infection means that the post operative treatment fell short of the requisite standard of care.

[156] The wound was painful, there was a horrible smell, there was pus and the skin turned yellow, black and green. Whilst Mrs Jaensch is entitled to some damages for the pain and suffering at that time, I am not able to find that debridement of the right breast at an earlier time would have been appropriate or that it would have significantly altered the cosmetic effect in that there would have been significantly less scarring. My recollection of the view is that there were folds in the skin of the right breast. I concluded that this did not amount to gross scarring as stated by Dr McLaren who apparently did not physically examine Mrs Jaensch. I prefer the evidence of Dr Gill who also made observations from the photographs and also did not examine Mrs Jaensch, that there is minimal evidence of a surgical scar. I

also accept the evidence of Professor Gough and Dr Gill that reconstruction of the breast is still possible and accept the opinion expressed by Dr Gill that "the changes seen are quite consistent with the removal of breast tissue without any form of immediate reconstruction".

[157] In summary, whilst I have found that the failure to arrange for more constant observation of Mrs Jaensch fell below the requisite standard of care and was negligent, I am not persuaded that such failure resulted in any substantial long term difference. Certainly Mrs Jaensch suffered pain and distress at having a smelly and ugly wound which could have been alleviated with closer attention. However, I am not satisfied on the balance of probabilities that debridement taking place on 6 January 1997 rather than 23 December 1996 or at any time prior to 6 January 1997, made any significant difference to the appearance of her right breast. Nor am I persuaded that it would have been appropriate to debride the wound on 23 December 1996 or at a date prior to 6 January 1997. I accept that surgical intervention could be premature and that it was preferable to wait until such time as the necrosis declared itself.

[158] Dr Scott conceded that where symptoms of the onset of necrosis are present, the situation may in fact entirely resolve itself.

[159] With respect to the time when the debridement should have occurred, Dr Scott and Dr Gibson appear to lean toward an opinion that the debridement should have been done earlier than 6 January 1997. However,

Dr Scott did concede that as a general statement it was necessary for there to be a demarcation of the necrosis before the debridement took place.

[160] Professor Gough stated that earlier debridement would probably not have resulted in less scarring and deformity.

[161] His opinion is supported by the evidence of Dr Gill.

[162] I accept the evidence of Professor Gough and Dr Gill on this aspect. I am not able to find that debridement of Mrs Jaensch's right breast earlier than 6 January 1997 would have been appropriate.

[163] Whilst I consider Dr Campbell's failure to ensure Mrs Jaensch was closely monitored between 23 December 1996 and 6 January 1997 falls short of a required standard of care, I am not able to find that the consequence of such failure to monitor was that the debridement of her right breast took place at a later time than it should have.

[164] I consider that the failure to ensure Mrs Jaensch was kept under close observation after 23 December 1996 caused her unnecessary distress and discomfort in those two weeks but did not detrimentally affect the long term consequence of the operation upon her.

[165] Accordingly, Mrs Jaensch's damages are limited to distress and discomfort, that could have been alleviated in the two weeks between 23 December 1996 and 6 January 1997, if arrangements had been made for her to receive regular attention from the community nursing sisters or other appropriate

persons in the absence of Dr Campbell. With constant observation and attention, the immediate effects of her condition, in particular her distress, could have been minimised. Dr Campbell himself gave evidence that a patient with Mrs Jaensch's symptoms required constant observation and attention. It would appear from the evidence that Dr Campbell believed he had arranged for community nurses to attend upon her after 16 December 1996. However, in fact these arrangements were not put in place till 6 January 1997.

[166] I am not able to find that there was scarring other than the normal scarring that occurs after such an operation.

[167] I do consider that Mrs Jaensch is entitled to an amount for the psychological effects which is limited to the psychological effects attributed to the failure to have her right breast closely observed and monitored between 23 December 1996 and 6 January 1997. Whilst she may feel distress at the sight of her right breast, the medical evidence which I have accepted, is that this is normal following a subcutaneous mastectomy and that reconstruction can be done. Whilst I accept Mrs Jaensch has a genuine fear of doctors as described by Dr McLaren, I consider that such fear is substantially attributable to the consequences of the misdiagnosis or delayed diagnosis of cancer to her left breast rather than to the actions of Dr Campbell. This is evident from Mrs Jaensch's own attitude when she consulted Dr Campbell about removal of her right breast. Mrs Jaensch undoubtedly feels a sense of grievance against Dr Campbell but she has not

established the substantial aspect of her claim against him in negligence. I accept that she must be allowed an amount for the distress and exacerbation of psychological fears in respect of doctors because there had been no appropriate arrangements put in place to keep her under close observation and monitor her wound following her attendance upon Dr Campbell on 23 December 1996. In the circumstances of this case I consider the failure to arrange for her to be attended by community nursing sisters or some other appropriate arrangement made, means that there was a failure to maintain the required standard of care.

[168] There was an agreement between the parties that special damages in the sum of $1250 arise in relation to the failure to warn claims. It is also agreed that in respect of the claim for negligent post operative management there is no claim for special damages. Accordingly, I do not award any amount for special damages.

[169] I would assess the amount of damages to be awarded to Mrs Jaensch in the sum of $2000. Judgment is entered in favour of the plaintiff in the sum of $2000.

[170] I grant leave to the parties to apply on the question of costs.

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