SUPREME COURT OF QUEENSLAND

File No 4405 of 2002

BETWEEN:

LLOYD ROBERT PARKIN

Applicant

AND:

RICHARD ANDREW LEWANDOWSKI & STATE OF QUEENSLAND

Respondent

MOYNIHAN J – REASONS FOR JUDGMENT

CITATION:	*Parkin v Lewandowski & Anor* [2003] QSC 097
PARTIES:	**Lloyd Robert Parkin** (Applicant) **v** **Richard Andrew Lewandowski** (First Respondent) And **State of Queensland** (Second Respondent)
FILE NO/S:	SC 10139 of 2000
DIVISION:	Trial Division
PROCEEDING:	Claim
ORIGINATING COURT:	Supreme Court of Queensland
DELIVERED ON:	11 April 2003
DELIVERED AT:	Brisbane
HEARING DATE:	24 – 26 March 2003
JUDGE:	Moynihan SJA
ORDER:	**1. The action is dismissed.**

CATCHWORDS:	DAMAGES – General Principles – Measure and remoteness of damage – Foreseeability of damage – whether the plaintiff was permanently disabled by a breach of duty of care by the defendant
COUNSEL:	Mr J Miles for the Applicant Ms JH Dalton for the Respondent
SOLICITORS:	Quinn & Scattini for the Applicant Hunt & Hunt for the Respondent

[1] On 24 November 1997 the plaintiff was admitted as a public patient to the Royal Brisbane Hospital conducted by the second defendant.

[2] On the 25 November, the first defendant, a specialist plastic and reconstructive surgeon employed, relevantly for present purposes, by the second defendant, carried out a conservative right total parotidectomy.

[3] During the course of the operation the plaintiff's facial nerve was severed causing him permanent disability. The plaintiff's case is that this was a consequence of the first defendant's breach of duty of care, for which the second defendant is vicariously liable, or is in breach of a non-delegable duty of care.

[4] The operation was a consequence of a chain of events which started in early to mid-September 1997. The plaintiff woke up with pain on the right hand side of his face, like someone had punched him in the jaw. He consulted his general practitioner who ordered an ultrasound. That and a subsequent CT scan confirmed the presence of a lump on the right hand side of the plaintiff's face in the vicinity of his jaw just in front of and below his ear.

[5] As a consequence of these outcomes the plaintiff's general practitioner referred him to a general surgeon who in turn referred the plaintiff to the first defendant, a surgeon specialising in plastic and reconstructive surgery, particularly of the head and neck.

[6] The first defendant saw the plaintiff on 23 October 1997. A fine needle biopsy was taken and sent for pathology testing. The plaintiff was referred for assessment to the Head and Neck Clinic of the Queensland Radium Institute at the Royal Brisbane Hospital.

[7] The pathology did not indicate the present of malignant cells but was nevertheless inconclusive. The tumour was a large one and appeared to be growing aggressively. It was recommended that the plaintiff have his right parotid gland removed, a complete right parotidectomy.

[8] The parotoid gland, a saliva-producing gland, is located just in front of the ear. A complete parotidectomy involved the removal of the whole of the gland. This is a delicate and difficult procedure principally because the gland is bisected by the facial nerve into superficial and deep segments. The facial nerve controls the movement of the muscles on the right side of the face.

[9] A complete right parotidectomy involves removal of both segments of the gland. As well as being bisected by the facial nerve the gland is close to the jugular vein and the carotid artery. The rupture or severance of either of them in the operation would be catastrophic. If the tumour capsule is ruptured in the course of the operation malignant cells are scattered into the body. Even if the tumour is benign the rupture of the capsule may lead to replication of the tumour because of the spillage of cells.

[10] Damage to the facial nerve is a recognized risk of a parotidectomy. Avoiding it requires application and skill on the part of the surgeon. Because of the risks the operation is usually undertaken by a surgeon experienced in the operation. The first defendant was qualified to carry it out.

[11] It was accepted at the trial that the surgery undertaken by the first defendant on 25 November 1997 was the only treatment appropriate in the plaintiff's circumstances. Even if the tumour was benign, as proved to be the case, the plaintiff was at risk because of its potential effect on his breathing and other functioning. As a consequence, whether or not the plaintiff had been adequately warned of the risks associated with the operation ceased to be an issue.

[12] The plaintiff's case essentially is that the first defendant failed to attain the standard of reasonable care and skill "of the ordinary skilled person exercising and professing to have" the special skill of a plastic and reconstructive surgeon specializing in head and neck surgery "including carrying out total conservative parotidectomies"; see *Rogers v Whitaker* (1992) 175 CLR 479 at 483. The non-delegable duty alleged against the second defendant is a failure to assume a particular responsibility to supervise the first defendant.

[13] The operation was conducted under general anaesthetic and the plaintiff has, of course, no knowledge of the events which occurred during it. A surgical registrar who assisted in the operation kept a record of it. The adequacy of the record has been questioned.

[14] In hindsight, given what occurred in the course of the operation it might have been useful if the record was more detailed. I am however satisfied that by the standards of the time at which it was made it is an appropriate record.

[15] The operation report relevantly notes:

> " 4. Main trunk of facial nerve identified and protected.

5. Dissection along five branches of the facial nerve identified and protected.
6. Superficial lobe parotoid gland removed.
7. Branches of facial nerve released and protected.
8. Deep lobe parotid gland removed ligation superficial femoral and maxillary artery.
9. Main trunk of facial nerve clipped with vascular clip and ~~avulsed~~ DIVIDED INADVERTENTLY (?) vessel).
10. Repair of main trunk of facial nerve 9/0 ??"

[16] The entries up to 9 are uncontroversial. As to 9, the first defendant directed the deletion of "avulsed" and the substitution of "DIVIDED INADVERTENTLY (? vessel)" when he reviewed the notes immediately following the operation. He did so because he considered that the nerve was not avulsed and that the alteration gave a correct description of what occurred.

[17] It may be accepted that to have intentionally clipped the main trunk of the facial nerve with a vascular clip and to have divided it was an occurrence to be avoided. The first defendant did not intend to do it. The issue is whether what occurred was a breach of his duty of care to the plaintiff.

[18] These proceedings were instituted on 22 November 2000. The second defendant then wrote to the first seeking a report in respect of the operation and its outcome. That was the first time since 25 November 1997 that the first defendant had been asked to consider the events of the operation, although I note he had continued to treat the plaintiff for a time after it.

[19] The first defendant's description of the operation in his response of 18 December 2002, relevantly for present purposes, was that the superficial lobe of the gland having been removed, the branches of the facial nerve were freed and protected. He went on:

> "In order to remove this mass, several large blood vessels had to be divided and the tumour had to be delivered from the parotid bed. This was undertaken with considerable difficulty and when the parotid mass was able to be delivered to the surface, it was tethered deeply to the base of this man's pharynx by blood vessels and other tissues. As this manoeuvre was undertaken, it displaced the facial nerve deeply beneath it due to the effect of its displacement. This made the deep cavity extremely difficult to see. Large blood vessels were treated by ligation with vascular clips and then division. Only the vessels that seemed to be passing directly into the parotid mass were divided. After division of these, it became apparent that the facial nerve trunk had been embedded in the mass on its undersurface and had been divided. This was identified immediately and repaired using micro-surgical techniques."

[20] The first defendant expanded on this account in his evidence. Having exposed the parotoid gland he identified the facial nerve by visualisation and progressively separated the two main branches protecting them as he progressed. This process delivered the superficial lobe of the gland, which was removed. He then mobilised the deep lobe in a similar fashion with a combination of sharp dissection and spreading, ligating the vessels as he went to control blood flow.

[21] In the plaintiff's case the deep lobe was attached to the large (4cm x 4cm) tumour, which had to be delivered up through the hole between the two main branches of the parotoid. This was a difficult task because of the size of the tumour which largely obscured the surgeon's vision. At the same time it was still attached to the base and had to be separated. This is done blindly with very restricted vision; essentially by feel.

[22] Dr Hallam, a surgeon experienced in the operation, described the exercise as "very difficult surgery". Dr Hallam himself had damaged facial nerves by inadvertent division. There are many times during the process when the facial nerve cannot be seen adequately or is obscured by blood. It is not always possible to identify where the nerve exited the skull, the first defendant gave evidence that in this case his ability to do so was restricted.

[23] The facial nerve can be damaged purely by traction, (pulling), inadvertent cutting or diathermy (an instrument used to staunch the blood flow). Dr Hallam referred to the facial nerve being adherent to the structure that is being removed and distorted by its anatomy as you remove the tumour, which involves pulling the mass outward and upward.

[24] Returning to the operation on the plaintiff the first defendant described reaching a stage where there had already been a "considerable amount of mobilisation to pull up the mass" which was "very tightly tethered" and which he was progressively freeing, careful of the risk of precipitating a catastrophic event by rupturing the carotid or jugular vein.

[25] The difficult part of the operation at this stage in terms of the risk of damage to the facial nerve was manoeuvring to free the tumour out of its deep space in the neck. Not only could the first defendant could not see any of the tethering structures, it was difficult to control the floating mass as it was progressively freed and manipulated.

[26] When last piece of the tethering tissue was freed the deep lobe of the parotoid came out. The first defendant was then able to see that part of the tethering tissue was actually the facial nerve, which he had unintentionally divided to free up the mass.

[27] During the course of the events which I have endeavoured to describe the tumour was pulled up under a lot of tension, the nerve was displaced in the process and pushed under the mass being extracted.

[28] I accept the first defendant's evidence as to the course of events the operation. His case that he exercised appropriate care and skill is substantially supported by the evidence of Drs Hallam, Harris and Kane who were called by the defendants, although the latter's evidence was directed more to the consequences of the operation.

[29] It was put to the first defendant that he could have taken further steps to protect the facial nerve before clipping of the arterial vessels. He stated that he knew of none and, none were explicitly put and I am satisfied there were none.

[30] I was invited to treat Dr Harris's evidence with circumspection because of his involvement with a medical insurer, in seeking to have limitations placed on a patient's right to sue doctors and his being a close professional colleague of the first defendants. It cannot be suggested that there is any impropriety in any of these connections and there is no basis for concluding that any of these considerations effected Dr Harris's evidence or judgment.

[31] The opinions of Dr Nicholson, who gave evidence for the plaintiff, were essentially formed on the basis of the operation record. He rightly pointed out it left many questions unanswered, I have nevertheless concluded it was a proper record.

[32] Dr Nicholson's opinion must yield to the evidence which is now available but which was not available at the time. His evidence certainly supports the evidence of the other doctors as to the complexities and risks inherent in the operation. Dr Nicholson accepted circumstances could arise where the facial nerve could be inadvertently divided without negligence. He seems to have come to the view, on the fuller exposition of the facts now available, that the damage to the facial nerve was in the circumstance "understandable" and something for which the first defendant is not to be criticised; see t 81, 82, 83.

[33] The risk of severance of the facial nerve is inherent in a total parotidectomy. It can occur even with the exercise of due care and skill by the surgeon. This is such a case. The case against the first defendant has not been worked out.

[34] The evidence does not found a conclusion that the second defendant was in breach of a non delegable duty to the plaintiff.

[35] The action should be dismissed, it however seems appropriate to assess damages. After the operation the first defendant spoke with the plaintiff telling him that his facial nerve had been damaged, that it would take approximately six months for it

to repair itself. In the meantime the plaintiff would have some loss of function on the right hand side of his face. That did not occur.

[36] The plaintiff has suffered a division of the main truck of his facial nerve which led to initially severe facial palsy that has somewhat ameliorated with time. He underwent a tarsorrophy, a partial sewing together of the eyelid of his right eye, to protect his eye; because he could not close it. This was subsequently reversed although the eyelid is not fully functioning. The plaintiff's right eye is sensitive to atmospheric conditions, notably dryness, dust and grit. The fact that his eyelid does not function effectively exposes him to risk of damage to the eye.

[37] The plaintiff also suffers from synkinese, a mass movement of muscle when he winks his right eye. It seems that this could be remedied by a minor operation although the plaintiff was not aware of this until cross examination. I take this into account in the assessment of general damages. Apart from this his condition is permanent.

[38] Because the plaintiff was unable to move the muscles on the right side of his face his speech was affected and he was referred to a speech therapist in an endeavour to restore the nerve function to activate the relevant muscles. He did not persist with this therapy for quite understandable reasons given the lack of progress and the effort involved in his travelling from his place of employment to the place where the therapy was carried out.

[39] While the majority of the plaintiff's dysfunction arises from the severing of the facial nerve there was some prospect of dysfunction as a consequence of the operation even if that had not occurred. The gustatory sweating experience by the plaintiff is a consequence of the surgery itself rather than of the division of the plaintiff's facial nerve.

[40] The asymmetry of the plaintiff's face as a consequence of his loss of muscular control is apparent although there is room for differences of opinion as to its extent.

[41] No doubt the plaintiff had undergone pain and suffering as a consequence of the severance of the facial nerve. The loss of symmetry and of function which I have described has caused him, and will continue to cause him, stress and makes him self conscious. He is entitled to be compensated for this and I make allowance in the assessment of general damages.

[42] I should say that while no doubt the aftermath of the operation of 27 November 1997 added to stresses in the plaintiff's marriage, I am not satisfied that they were a significant cause in the break up of the marriage. I note that at the trial he was in another relationship.

[43] I turn to the assessment of damages on the basis of:

PAIN, SUFFERING AND LOSS OF AMENITY

[44] I will not repeat what I have already said in respect of this.

I allow	$40,000.00
Interest on $25,000 (2% x 5.33 year) calculate	$2,665.00

EARNING CAPACITY (PAST)

[45] I have already dealt with aspects of this topic and will not repeat what I said earlier. The plaintiff did not return to work until 18 January 1999. He apparently did not attempt to do so earlier because he continued to be in receipt of medical certificates justifying sickness benefits. He was and remains justifiably concerned about the risk of injury to his eye and the discomfort it gives him in dusty conditions. In the circumstance it is explicable that he did not attempt to return to work earlier.

[46] The plaintiff had left his employment at Welder Tube Mills in June 1996 for reasons unrelated to anything arising for consideration in this action. Shortly thereafter commenced work as a sealer/water proofer, his current occupation. He was apparently a sub contractor rather than an employee. That ceased in September 1997 and the plaintiff did not obtain further employment before the operation of 25 November in that year.

[47] On 18 January 1999 the plaintiff commenced in his present employment, although from July 2001 to February 2002 he was on Centrelink benefits before resuming the employment. He has continued there until the date of trial.

[48] I do not think it is justifiable to assess the plaintiff's past economic loss by the measure of earnings had he been employed by Welder Tube Mills.

PAST ECONOMIC LOSS

[49]	I allow	$35,000.00
	Interest (5% of $10,000)	$500.00
	Loss of superannuation benefit 7%	$2,450.00

LOSS OF EARNING CAPACITY (FUTURE)

[50] In my view the evidence does not justify approaching the calculation of the plaintiff's loss of future earning capacity on the basis that he would be employed in a steel mill earning at a higher rate than he would do as a sealer and waterproofer. As I have indicated there should be some allowance reflecting the fact that he may from time to time have exercised that capacity and his injury, particularly the effect on his ability to close his eyelid, inhibited him doing so.

[51] The probability is that for most of his working life but for the operation of 25 November 1997 and its aftermath the plaintiff would have been in his present occupation. His earning capacity is diminished because he may not have a sympathetic employer, as he currently does, and other employers may be more reluctant to take him on.

I allow	$50,000.00
Loss of superannuation contribution (at 9%)	$4,500.00

SPECIAL DAMAGES

[52] These are agreed in the amount of	$1,217.60

ANY FUTURE PHARMACEUTICAL EXPENSES

[53] This relates to eye drops and medication for the plaintiff's eye, these are essentially agreed.

I allow	$4,290.00
TOTAL:	$140,622.60

[54] I give judgment for the defendants and dismiss the plaintiff's action.