SUPREME COURT OF QUEENSLAND

CITATION:	*Broadbent v Medical Board of Queensland* [2010] QCA 352
PARTIES:	**MICHAEL RUSSELL MARK BROADBENT** (registrant/applicant) **v** **MEDICAL BOARD OF QUEENSLAND** (applicant/respondent)
FILE NO/S:	Appeal No 7059 of 2010 QCAT No 976 of 2008 QCAT No 1189 of 2008 QCAT No 2962 of 2007
DIVISION:	Court of Appeal
PROCEEDING:	Miscellaneous Application - Civil Application for Leave s 149(2) QCAT Act
ORIGINATING COURT:	Queensland Civil and Administrative Tribunal at Southport
DELIVERED ON:	10 December 2010
DELIVERED AT:	Brisbane
HEARING DATE:	11 November 2010
JUDGES:	Fraser and Chesterman JJA and McMurdo J Separate reasons for judgment of each member of the Court, each concurring as to the orders made
ORDERS:	**1. Respondent's application refused;** **2. Applicant to pay the Respondent's costs of its application, including reserved costs;** **3. Application for leave to appeal refused with costs.**
CATCHWORDS:	PROFESSIONS AND TRADES – LAWYERS – DUTIES AND LIABILITIES – COUNSEL AND CLIENT – AUTHORITY TO COMPROMISE – where the applicant applied to this Court for leave to appeal – where the respondent applied for a declaration that the appeal had been compromised – where the applicant's counsel made a settlement offer to the respondent – where the applicant then instructed his legal representative, his son, to withdraw the offer – where the offer was not withdrawn – where the respondent accepted the offer – whether the compromise is a valid contract binding on the applicant – whether the contract of compromise was subject to ratification – whether the offer was accepted within a reasonable time – whether the applicant's counsel had actual or apparent authority to conclude a contract on the applicant's behalf – whether the Court should enforce the compromise

APPEAL AND NEW TRIAL – APPEAL - PRACTICE AND PROCEDURE – QUEENSLAND – WHEN APPEAL LIES – BY LEAVE OF THE COURT – GENERALLY– where the applicant was previously a medical practitioner and general surgeon – where the respondent commenced disciplinary proceedings against the applicant in relation to his treatment of 13 patients – where the Queensland Civil and Administrative Tribunal considered the applicant's treatment of two patients and found the applicant had displayed unsatisfactory professional conduct in relation to both patients – where the Tribunal conducted a thorough and detailed analysis of the evidence – whether the Tribunal ignored facts relating to the first patient's ingestion of senna tea and the second patient's anastomotic leak – whether the tribunal's findings of fact could not reasonably have been made

Health Practitioners (Professional Standards) Act 1999 (Qld), s 31, s 124(1)(a), s 241(2)(d)
Queensland Civil and Administrative Tribunal Act 2009 (Qld), s 149(2), s 149(3)(b), s 149(2), s 154(2)

Ballas v Theophilos (No 2) (1957) 98 CLR 193; [1957] HCA 90, applied
Broadbent v Medical Board of Queensland [2010] QCA 311, related
Cole v Cottingham (1837) 8 C & P 75; (1837) 173 ER 406; [1837] Eng R 872, applied
Coomber v Stott [2007] NSWSC 513, cited
Fletcher v Queensland Nursing Council [2009] QCA 364, cited
Harvey v Phillips (1956) 95 CLR 235; [1956] HCA 27, applied
Insbury Pty Ltd v Craig [1990] 1 Qd R 309, discussed
IVI P/L v Baycrown P/L [2005] QCA 205, discussed
Manchester Diocesan Council For Education v Commercial and General Investments Ltd (1969) 21 P & CR 38; [1969] 3 All ER 1593, applied
Marsden v Marsden [1972] Fam 280; [1972] 2 All ER 1162, cited
Neale v Gordon Lennox [1902] AC 465, applied
Newbrook v Marshall (2001) 16 PRNZ 67; [2002] 2 NZLR 606, cited
Sheonandan Prasad Singh v Abdul Fateh Mohammad Reza (1935) 62 Ind App 196, cited
Taylor v Johnson (1983) 151 CLR 422; [1983] HCA 5, cited
Telina Development Pty Ltd v Stay Enterprises Pty Ltd [1984] 2 Qd R 585, applied
Toll (FGCT) Pty Ltd v Alphapharm Pty Ltd (2004) 219 CLR 165; [2004] HCA 52, cited
Transmetro Corp Ltd v Davy & Ors [2005] QCA 239, applied
Wandel & Golterman GMBH & Co v Wandel Global Services Pty Ltd [2002] FCA 1609, cited

Yeshiva Properties No 1 Pty Ltd v Lubavitch Mazal Pty Ltd [2003] NSWSC 615, applied

COUNSEL: The applicant appeared on his own behalf
K A McMillan SC, with J Farr, for the respondent

SOLICITORS: The applicant appeared on his own behalf
Moray and Agnew Lawyers for the respondent

[1] **FRASER JA:** The applicant, Mr Broadbent, was formerly a medical practitioner and general surgeon. The respondent Board referred disciplinary proceedings to the Health Practitioners Tribunal against the applicant in relation to his treatment of 13 patients. That tribunal was subsequently replaced by the Queensland Civil and Administrative Tribunal (QCAT). Thereafter, the respondent's proceedings in relation to two patients, Mrs MacLeod and Mrs Pearce, proceeded to a hearing in QCAT. At the hearing QCAT was constituted by Wall DCJ, who was assisted by Dr P Richardson, Dr G Powell and Ms G Bolland. After a lengthy hearing, on 10 June 2010 QCAT decided that unsatisfactory professional conduct had been established in relation to the treatment of Mrs MacLeod and Mrs Pearce. Directions were given for a subsequent hearing on penalty and costs.

[2] On 2 September 2010 QCAT accepted the submission made for the applicant that the appropriate penalty was to require the applicant to give an undertaking under s 241(2)(d) of the *Health Practitioners (Professional Standards) Act* 1999 (Qld). The applicant gave the required undertaking and QCAT recorded the following decision:

> "The Registrant having, pursuant to section 241(2)(d) of the *Health Practitioners (Professional Standards) Act 1999*, given an undertaking to the Tribunal in the following terms:-
>
> > "I, Michael Russell Mark Broadbent, undertake that, the Tribunal having found that grounds for disciplinary action are established in the respects referred to by the Tribunal in its judgment delivered on 10 June 2010
> >
> > (i) I will retire permanently from medical practice;
> > (ii) I will never reapply to the National Board for the Health Profession for registration in Australia as practising medical practitioner:
> > (iii) I will not seek to be relieved of this undertaking"
>
> details of the undertaking be recorded in the Board's register for the period for which the undertaking is in force pursuant to section 242(1)(b) of the *Health Practitioners (Professional Standards) Act 1999*."

[3] The disciplinary proceedings concerning the remaining 11 patients were listed for a directions hearing on 26 November 2010.

[4] On 7 July 2010 the applicant filed an application for leave to appeal to this Court from the decision of the Tribunal. Section 149(2) of the *Queensland Civil and Administrative Tribunal Act* 2009 (Qld) confers a right of appeal against a decision of this kind where, as here, QCAT was constituted by a judicial member. That is qualified by the provision in s 149(3)(b) that an appeal on a question of fact or a question of mixed fact and law lies only by the Court's leave.

[5] Subsequently the respondent contended that the applicant had agreed to compromise his proposed appeal. The applicant denied the alleged compromise. The respondent applied for declarations that on 11 October 2010 the applicant and respondent had agreed to discontinue the applicant's appeal and that the terms of that agreement required the applicant to discontinue the proceeding currently before the Court. The respondent sought orders that the appeal be dismissed and that the applicant pay the respondent's costs of the appeal on and from 11 October 2010 and the costs of the respondent's application.

[6] The Court heard the application for leave to appeal immediately after the Court had heard and reserved its decision upon the respondent's application.

The compromise

[7] The evidence relating to the compromise was contained in affidavits by the applicant and by the respondent's solicitor. The applicant was represented in the negotiations by O'Keefe Mahoney Bennett, the solicitors who acted for him in the legal proceedings. The applicant's son Mr Hamish Broadbent was an employed solicitor with O'Keefe Mahoney Bennett. He had the day to day carriage of the applicant's matter.

[8] The applicant deposed that after counsel retained for him in the proceedings in this Court reported on 21 September 2010 that to settle the proceedings a "formal offer" would be needed from the applicant, and after he was again under pressure to make an offer, he "eventually and reluctantly agreed to put the offer." The applicant's offer was made on 22 September 2010 by his counsel's email to the respondent's counsel and solicitor:

> "…Dr Broadbent makes the following offer on a without prejudice basis –
>
> A) appeal dismissed by consent;
>
> B) no order as to costs of the appeal;
>
> C) on Dr Broadbent's undertaking already given to QCAT, all remaining referral notices are to be permanently stayed;
>
> D) as to the costs in the Pearce and McLeod (sic) matters, the costs are to abide the decision of the Tribunal presently reserved. Thanks."

[9] The respondent's solicitor replied by email on the same day seeking clarification in relation to C):

> "Is it your client's position that he accepts that the permanent stay of the referral notices is to be premised on the undertaking remaining in force? That is, should he seek to be relieved of the undertaking in the future or otherwise seek review of it, the permanent stay is lifted?"

The applicant's counsel replied immediately that the intention of the wording was to reflect that the stay was premised on the undertaking, so that if the undertaking was resiled from the respondent could apply to have the stay lifted.

[10] On 5 October the applicant's counsel sent an email to the respondent's counsel enquiring whether there was any progress on the applicant's settlement offer. The respondent's solicitor replied that he had sought instructions and would revert to the applicant's counsel as soon as he possibly could. The applicant's counsel thanked the respondent's solicitor for that information.

[11] The applicant deposed that once he had agreed to put the offer he had "very serious and deep renewed soul searching" about the matter. In an email to Mr Hamish Broadbent sent early in the afternoon of 6 October, the applicant observed that the "injustice of the whole situation will burn me for the rest of my life unless I finish the appeal", and that he would almost certainly reject any offer from the respondent. The applicant enquired about what was required to be done next in pursuing his appeal.

[12] Later on 6 October Mr Hamish Broadbent replied that the respondent had made no offers and the only offer had been made by the applicant, and that:

> "Your offer to withdraw the appeal on basis that Board does not pursue costs, is still on the table. If you are saying you no longer wish to make that offer, you better withdraw it… You will also need to consider legal representation – my firm will not allow me to work any further on this matter, unless you pay for everything outstanding."

A subsequent passage in the email enquired whether the applicant's instructions were to withdraw his offer.

[13] The applicant responded in an email sent late at night on 6 October. He set out how he proposed to approach the appeal and he referred to his "further hope" that the Board would consider an independent review of the evidence as an alternative to the appeal, having regard to what the applicant considered was a requirement of Federal legislation for an independent peer review of the facts. The applicant suggested the possibility of proceedings in the Federal Court and he described "the deal I would believe the [respondent] might entertain".

[14] On 7 October Mr Hamish Broadbent replied that he would not be in his office on the following day and he sought clear instructions whether the applicant was withdrawing his offer and wanting to press on with the appeal. The applicant replied by the following email on Friday 8 October at 6.53am:

> "H
>
> I am withdrawing my instructions i (sic) regard to [the applicant's counsel] and negotiations with the vBoard (sic)
>
> I am pressing on with the Appeal
>
> I am available to assist with photocopying this weekend
>
> R"

[15] Mr Hamish Broadbent replied on 8 October that, "I am unavailable today and all weekend. I am moving house."

[16] Attached to one of the applicant's affidavits is what appears to be a copy of an email sent to the applicant by Mr Hamish Broadbent on 8 October at about 1.11 pm,

which forwarded the following email sent by the applicant's counsel to Mr Hamish Broadbent earlier on the same day:

> "My chase up drew an apology and a promise to renew the pursuit of instructions. I think [the respondent's counsel] is back on Monday so I may get a better chance of extracting a response then. . . ."

The applicant swore that he was aware that there was a communication between his solicitor and his counsel on 8 October, but he submitted that by this he did not mean to convey that he was aware of it at the time; rather he was aware of it when he swore his affidavit. However the applicant did not give any evidence denying that he became aware of that email exchange on 8 October.

[17] By email from the respondent's solicitor to the applicant's counsel at 9.03 am on Monday 11 October the respondent accepted the applicant's offer and asked for confirmation of receipt of that email. A few minutes later the applicant's counsel responded that he had received the email and would ask his instructing solicitor to liaise with the respondent's solicitor regarding the necessary formal steps. The applicant's counsel forwarded the emailed acceptance to Mr Hamish Broadbent. He forwarded those emails to the applicant, stating that his offer was accepted and that, "I did not have time on Friday or this morning to withdraw it".

[18] At about midday on the same day, Mr Hamish Broadbent sent to the applicant a letter advising that the applicant's offer had been accepted at 9.03 am and would need to be formalised by way of a written document. He acknowledged that on 8 October 2010 the applicant had emailed instructions requesting that the offer be withdrawn and that the appeal be pursued. He stated that the Board accepted the offer at 9.03 am on 11 October before the applicant's instructions were "actioned" because "the writer was on leave, and the weekend intervened". He informed the applicant that O'Keefe Mahoney Bennett declined to act on any further instructions from the applicant unless he first paid an amount for outstanding costs. Since then the applicant has acted for himself.

[19] On the afternoon of 11 October the applicant sent the respondent's solicitor a letter in which the applicant denied that he had compromised his appeal. The respondent contended that his offer "was withdrawn by myself through O'Keefe Mahoney Bennett on 8th October and your notification today came too late. I had already changed my instructions."

Was there a contract of compromise?

[20] The terms of the applicant's offer were straightforward. If there was any ambiguity in paragraph C), that was cleared up in the subsequent email exchange on the same day. On the face of the email exchanges the applicant contracted by his counsel with the respondent by its lawyers to compromise the proposed appeal.

[21] The applicant argued that any contract was subject to ratification. He argued that this was so because in the normal course counsel negotiating a compromise would report back to instructing solicitors, who would report back to their clients. In most cases counsel and solicitors do obtain actual authority from their clients to compromise litigation in which they are retained, but that does not deprive a solicitor or counsel conducting litigation of their usual apparent authority to bind

their clients to a compromise.[1] Here, as the applicant accepted, his counsel also had actual authority to make the offer. The respondent accepted that offer, which did not include any condition that the proposed compromise was subject to subsequent ratification by either party. On the necessary objective construction of the resulting contract,[2] the compromise was not subject to ratification.

[22] The applicant argued that it was implicit that his offer should be accepted or rejected within a reasonable time. The law provides that an offer which does not specify a time within which it must be accepted, must be accepted within a reasonable time.[3] The applicant argued that, having regard to the litigation in QCAT and in this Court, a reasonable time expired two or three days after the offer was made on 22 September. The parties' conduct subsequent to the making of the offer should be taken into account in deciding whether an offer was accepted within a reasonable time.[4] Both parties treated the offer as remaining open for acceptance in their lawyers' exchange of emails on 5 October and they did so even though it was apparent that the respondent's instructions were yet to be obtained. Bearing that in mind, I would hold that a reasonable time for acceptance of the offer had not elapsed before the respondent accepted that offer early on 11 October.

[23] The applicant also argued that he had effectively revoked his offer and terminated his solicitor's agency by an email to his solicitor on 8 October. He argued that it was his solicitor's duty to communicate the withdrawal of the offer so that the applicant's offer was revoked by way of a "constructive communication to the respondent". It is trite law that to be effective the withdrawal of an offer must be communicated to the offeree. Thus, for example, in *IVI P/L v Baycrown P/L*[5] McPherson JA said:

> "An offer may be withdrawn or revoked at any time before it is accepted. To be effective the withdrawal must be communicated to the offeree. On this, the leading texts are at one: see *Chitty on Contracts*, § 2-087, at 163 (29th ed); *Williston on Contracts* § 5.9, at 671 (4th ed); *Corbin on Contracts* §2.19 (rev ed), at 223-225, who says, more precisely, that notice of revocation of the offer must be "received" by the offeree. In this respect, those writers tend to equate the requirements for communicating withdrawal of an offer with those for communication of an acceptance."

No notice of revocation of the applicant's offer was given to the respondent before it accepted the offer. The offer therefore remained open for acceptance when the respondent communicated its acceptance to the applicant's counsel on 11 October. The applicant's counsel undoubtedly had apparent authority to receive that

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1 See the discussion in Foskett, David, *The Law and Practice of Compromise*, (6th Ed, 2005) at paragraphs 29-04 to 29-10.

2 See *Taylor v Johnson* (1983) 151 CLR 422 at 429; *Toll (FGCT) Pty Ltd v Alphapharm Pty Ltd* (2004) 219 CLR 165 at 179, paragraph [40].

3 *Ballas v Theophilos (No 2)* (1957) 98 CLR 193 per Williams J at 199, and per Dixon CJ at 197, with McTiernan concurring. See also *Transmetro Corp Ltd v Davy & Ors* [2005] QCA 239 per Muir JA at [24], with McMurdo P and Philippides J agreeing.

4 *Manchester Diocesan Council For Education v Commercial and General Investments Ltd* (1969) 21 P & CR 38; [1969] 3 All ER 1593 per Buckley J at 1599. The same approach is adopted when determining whether a reasonable time has elapsed for the purposes of compliance with contractual conditions: see *Telina Development Pty Ltd v Stay Enterprises Pty Ltd* [1984] 2 Qd R 585 per Connolly J at 591 to 592.

5 [2005] QCA 205 at [1].

communication so as to bind the applicant to the compromise at that time.[6] In any event, the respondent's acceptance of the offer was communicated to the applicant himself later on the morning of 11 October before he gave notice to the respondent that he did not wish to settle. If, contrary to my view, the applicant's counsel did not retain apparent authority to conclude a contract by receiving an acceptance of the offer on the applicant's behalf, a contract was concluded when the applicant received notice of that acceptance from his own solicitor.[7]

[24] Upon a contractual analysis the compromise is a valid contract binding upon the applicant.

[25] The applicant argued that a contractual analysis was inappropriate because the compromise abrogated his "constitutional right" to appeal from a "quasi-criminal tribunal" and because the compromise was in substance a "plea bargain" which could not preclude the applicant from subsequently pursuing his appeal. There is no such constitutional right. The issue is not whether there could be a compromise of the proceedings in QCAT but whether there could be a compromise of the applicant's right to seek leave to appeal from QCAT's decision. The applicant did not advance any persuasive reason why he might not make a binding contract to abandon that right. The applicant's analogies with criminal proceedings and "plea bargains" are not helpful. That the proceedings in QCAT had a disciplinary character and were designed to vindicate a public interest do not suggest that the applicant and respondent were not free to make a contract under which the applicant surrendered his right to apply for leave to appeal from QCAT's decision to this Court.

Enforcement of the compromise

[26] The applicant argued that the Court should not enforce the compromise. The respondent accepted that in some circumstances courts are empowered to refuse to enforce a compromise of litigation made by the agency of the parties' legal representatives retained in that litigation but the respondent argued that the power did not arise here because the compromise was made with the applicant's authority. The respondent also argued that if the power did exist this was not an appropriate case for its exercise.

[27] The High Court discussed the relevant power in *Harvey v Phillips*.[8] In that case a plaintiff was temporarily overborne by extreme pressure exerted upon her by her counsel, solicitor, and perhaps others, reluctantly to consent to a compromise of her damages claim in the Supreme Court of New South Wales. Senior counsel on each side signed a document recording the terms of the settlement and a judge authorised the entry of judgment in accordance with the terms of settlement. Judgment had not been signed or entered before the plaintiff applied to set aside the compromise. She had disowned the compromise the morning after she had consented to it. In holding that in those circumstances the Supreme Court did not have any power to set aside the compromise or to intercept the formal entry of judgment, Dixon CJ, McTiernan, Williams, Webb, and Fullagar JJ said: [9]

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6 See *Insbury Pty Ltd v Craig* [1990] 1 Qd R 309 per Byrne J at 313; *IVI P/L v Baycrown P/L* [2005] QCA 205 per Keane JA at [33] and footnote 8.

7 *Yeshiva Properties No 1 Pty Ltd v Lubavitch Mazal Pty Ltd* [2003] NSWSC 615 per Young CJ in Eq at [45] citing *Cole v Cottingham* (1837) 8 C & P 75; (1837) 173 ER 406.

8 (1956) 95 CLR 235.

9 (1956) 95 CLR 235 at 242 to 244.

> "It is not a case where the assistance of the court is sought or invoked to carry a compromise into effect which otherwise could not be enforced by the party relying upon it. In such a case the assistance may be refused on grounds not necessarily sufficient to invalidate a simple contract. It is not a case where a compromise has been agreed upon by counsel acting only in pursuance of his apparent or implied authority from his client but, owing to a mistake or misapprehension, in opposition to his client's instructions or in excess of some limitation that has been expressly placed on his authority. In such a case, at all events until the judgment or order embodying the compromise has been perfected, an authority exists in the court to refuse to give effect to or act upon the compromise and perhaps to set it aside: see *Neale v Gordon Lennox* (1902) AC 465, particularly at pp 469, 470, 473; *Shepherd v Robinson* (1919) 1 KB 474; *Little v Spreadbury* (1910) 2 KB 658, at p 662, per Bray J; *Hansen v Marco Engineering Co (Aust) Pty Ltd* (1948) VLR 198, at pp 201-203, per Fullagar J; *Schwarz v Clements* (1944) 171 LT 305, at p 309. In the course of the judgment in the case of *Sheonandan Prasad Singh v Abdul Fateh Mohammad Reza* (1935) 62 Ind App 196, already cited, Lord Atkin said that these cases qualified the implied authority of counsel to compromise an action. "In the first instance the authority is an actual authority implied from the employment as counsel. It may, however, be withdrawn or limited by the client; in such a case the actual authority is destroyed or restricted, and the other party if in ignorance of the limitation could only rely upon ostensible authority. In this particular class of contract, however, the possibility of successfully alleging ostensible authority has been much restricted by the authorities such as *Neale v Gordon Lennox* (1902) AC 465 and *Shepherd v Robinson* (1919) 1 KB 474, which make it plain that if in fact counsel has had his authority withdrawn or restricted the Courts will not feel bound to enforce a compromise made by him contrary to the restriction, even though the lack of actual authority is not known to the other party" (1935) 62 Ind App, at pp 199, 200. It is said that this power of the courts is to be exercised as a matter of discretion when in the circumstances of the case to allow the compromise to stand would involve injustice in view of the restriction on counsel's authority. See *Halsbury's Laws of England*, vol. 3, 3rd ed., p. 51; 2nd ed., vol. 2, pp. 526, 527. But in the case of a compromise which is made within the actual as well as apparent authority of counsel a court does not appear to possess a discretion to rescind it or set it aside. The question whether the compromise is to be set aside depends upon the existence of a ground which would suffice to render a simple contract void or voidable or to entitle the party to equitable relief against it, grounds for example such as illegality, misrepresentation, non-disclosure of a material fact where disclosure is required, duress, mistake, undue influence, abuse of confidence or the like."

[28] In this case, as in *Harvey v Phillips*, a judgment bringing the proceeding to an end is sought to reflect the applicant's contractual abandonment of his litigation but no further order is required to give effect to the compromise. The High Court did not regard the formal entry of a judgment dismissing the claim in accordance with the

compromise as amounting to such "assistance of the court… to carry a compromise into effect" as might be refused on grounds not sufficient to invalidate a contract, but in that case the Supreme Court had made an order that judgment be entered. All that was required before the plaintiff sought relief from the compromise was the formal entry of judgment pursuant to an existing order. In this case the applicant repented of the compromise before the Court had made any order. The respondent does require the Court's assistance to enforce the compromise, at least to the extent of an order refusing leave to appeal. The respondent has also sought the Court's assistance by way of declaratory relief.

[29] On the applicant's evidence it is clear that he authorised the offer to compromise his appeal only with great reluctance and under significant commercial and other pressures, but those matters are insufficient to justify the Court's refusal to enforce the compromise. The power to decline to enforce a compromise does not arise where the party who seeks to impeach the compromise expressly authorised the compromise, even if that authority was given after considerable equivocation and under pressure. That is so, provided that there is no ground sufficient to render the compromise void or voidable or to entitle the client to equitable relief. The applicant did not argue that there was any such ground.

[30] The applicant's more substantial argument was that he should be relieved from the compromise because it was contrary to his instructions to his solicitor.

[31] The respondent argued that the applicant should himself have notified the respondent that the applicant revoked his offer if he intended to pursue his proposed appeal. In that respect the respondent referred to the applicant's knowledge by 8 October that his offer might be accepted on 11 October and that Mr Hamish Broadbent would be out of the office and otherwise occupied between 8 and 10 October, and to Mr Hamish Broadbent's statements on 6 October that his firm insisted on payment of outstanding legal fees, and "you better withdraw" the offer. I do not accept the argument. It is far from being clear that the applicant understood or should have understood that acceptance of his offer would immediately create a binding contract. So far as the evidence reveals, he was not given that advice until after his offer was accepted. In any case, Mr Hamish Broadbent's statement that "you better withdraw" the offer conveyed no more than advice that the applicant should give instructions to withdraw the offer if he wished to pursue his appeal. So much appears from the subsequent request for instructions in the same email (see paragraph [12] of these reasons) and again on the following day, 7 October.

[32] In response to Mr Hamish Broadbent's request on 7 October for concise instructions the applicant made it clear in his reply early on Friday 8 October that he did not wish to compromise. At that time there was a prospect that the respondent might accept the applicant's offer at any moment and, according to the email from the applicant's counsel on the same day, there was a very real prospect that the offer might be accepted on the following Monday. The fact that the employed solicitor who had the carriage of the matter was on leave was not a reasonable basis for the applicant's solicitors' failure to act upon the applicant's clear instructions. There was amply sufficient time for the applicant's solicitors, whether by Mr Hamish Broadbent or by another employee who was not on leave, to have given notice to the respondent's lawyers revoking the offer before it was accepted on 11 October. I emphasise that the applicant's solicitors are not parties to this

litigation and the evidence was confined to that which the parties adduced, but on that evidence it was reasonable for the applicant to assume that his solicitors would do what was necessary to act upon his instructions that he did not wish to compromise his proposed appeal. On that evidence the applicant's solicitors readily could have withdrawn his offer and they should have done so.

[33] This matter is therefore analogous to the case described by the High Court in *Harvey v Phillips* where a compromise has been agreed upon by counsel acting in pursuance only of an apparent authority from the client, but in opposition to the client's instructions. The analogy is not precise. It was the applicant's solicitor rather than counsel who did not give effect to the applicant's instructions but that difference is not a valid point of distinction.[10] Another difference is that the offer was made with the express authority of the applicant and the applicant himself received notice of communication of acceptance of it from his own solicitor before the offer was revoked, so that no question of the authority to contract of the applicant's counsel or solicitors arises. It is nonetheless clear that the compromise was made in defiance of the applicant's instructions. In this context I do not see a valid distinction between an offer to compromise litigation made without the client's express authority by counsel retained in the case and the inexplicable failure of the retained solicitors to give effect to clear instructions to withdraw an offer where there was no apparent difficulty in withdrawing the offer before it was accepted. The Court does have the power to refuse to give effect to the compromise in this case.

[34] Should the court exercise that power? In *Harvey v Phillips* it was not necessary for the High Court to give any guidance about the manner in which the discretion should be exercised, but the Court referred to the statements in the second and third editions of *Halsbury's Laws of England* that the power is to be exercised as a matter of discretion when, to allow the compromise to stand would involve injustice in view of the restriction on counsel's authority. The statements in both editions of *Halsbury* were that:

> "When, in the particular circumstances of the case, grave injustice would be done by allowing the compromise to stand, the compromise may be set aside, even though the limitation of counsel's authority was unknown to the other side."[11]

[35] The authority cited for that proposition was *Neale v Gordon Lennox*.[12] In that case counsel consented to an action for slander and liable being referred out of the court without giving effect to the plaintiff's insistence that the defendant's counsel should first publicly state that there was no ground for the "grave and slanderous words of the plaintiff". Earl Halsbury LC regarded the omission to comply with that condition of the plaintiff's consent to the reference as producing "so gross an injustice that, upon the general jurisdiction that every Court has over its own procedure, this Court ought to refuse to allow that injustice to be committed";[13] he

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10 See *Insbury Pty Ltd v Craig* [1990] 1 Qd R 309 per Byrne J at 314 to 315, and the authorities analysed by his Honour. Byrne J's decision, and other decisions to the same effect, were followed by Finkelstein J in *Wandel & Golterman GMBH & Co v Wandel Global Services Pty Ltd* [2002] FCA 1609 at [4].

11 Lord Simonds (Ed), *Halsbury's Laws of England*, vol. 3, (3rd ed.,1953) at p 51; Viscount Hailsham (Ed), *Halsbury's Laws of England*, vol. 2 (2nd ed., 1931) at pp 526, 527.

12 [1902] AC 465.

13 [1902] AC 465 at 472.

could "hardly conceive a case in which there is a more prominent and more important principle involved than a case in which a person is coming to vindicate her character in public".[14] It is apparent from the decision that the absence of any injustice to the other side which could not be cured by an order for costs was also a relevant consideration. The requirement that the compromise would produce a "grave injustice" remains in the current edition of *Halsbury*,[15] which cites *Marsden v Marsden*.[16] In that case Watkins J approved of the statement in the earlier edition. That test has been applied in New South Wales[17] and in New Zealand.[18] Similarly, in Foskett's *The Law and Practice of Compromise*[19] it is said that the courts' power should be exercised "with considerable caution and only where a clear injustice would arise if it were not exercised."

[36] Any rejection of the principle that the courts retain the discretion in some circumstances to refuse to enforce a contractually valid compromise of litigation must occur in the High Court, but in my opinion the discretion should be exercised with caution and only where it is clearly demanded by the interests of justice. The growth of email and other forms of virtually instantaneous communication has made it relatively easy and commonplace for solicitors and counsel promptly to obtain and act upon express instructions in negotiations to compromise litigation, even where the clients are physically remote from the lawyers. In these circumstances, which differ from those which prevailed when this power in the courts was held to exist, a party to litigation should be able to rely upon the apparent authority of the opposite party's lawyers to compromise the litigation, within the well known limits of that apparent authority. If the courts too readily disregard compromises of litigation made by the parties' lawyers the important aim of promoting settlement of litigation will be hindered and resources will be wasted on investigating disputes which should properly be confined between lawyer and client who, unlike the opposite party, should readily be able to prove whether or not a particular compromise reflected the client's instructions.

[37] On the present state of the law, a distinction must be drawn between the authority of counsel and solicitors to compromise litigation in which they are retained and the authority of agents generally to bind their principals to contracts. That is required by the High Court's approval in *Harvey v Phillips* of Lord Atkin's statement in *Sheonandan Prasad Singh v Abdul Fateh Mohammad Reza* that the implied authority of counsel to compromise an action is qualified by the courts' power in the interests of justice in some cases to disregard the compromise. It does not follow, however, that the mere fact that a lawyer lacks actual (express or implied) authority to compromise litigation constitutes an injustice which justifies the exercise of that power. Our system of law has long adopted the doctrine that contracts are generally valid if made by an agent with the apparent authority of the principal even if the agent acts in defiance of the principal's instructions. Adjectives such as "clear", "serious" and "grave" cannot define the nature or degree of the injustice which suffices to justify the exercise of the courts' power as an exception to that general rule, but they do serve to emphasise that, whilst the compromise of litigation

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14 [1902] AC 465 at 471.

15 Lord Mackay (Ed), *Halsbury's Laws of England*, vol. 66, (5rd ed., 2009) at p 339, paragraph 1138.

16 [1972] Fam 280; [1972] 2 All ER 1162.

17 *Coomber v Stott* [2007] NSWSC 513 at [31] to [35] per Macready AsJ.

18 *Newbrook v Marshall* [2002] 2 NZLR 606 at [16] per Richardson P, Gault and Tipping JJ.

19 Foskett, David, *The Law and Practice of Compromise*, (6th Ed, 2005) at pp 330 to 331, paragraphs 29-20 to 29-21.

contrary to the client's instructions might be regarded as always involving an injustice, that is not necessarily sufficient. So much is consistent with the description in *Harvey v Phillips* of the courts' power to disregard a compromise in that and other cases as an "authority" and "discretion".

[38] Applying the appropriately stringent test, the facts of this case do justify the exercise of the Court's power to decline to enforce the compromise. This matter has many of the features of *Neale v Gordon Lennox*, which the House of Lords regarded as a clear case for the exercise of the power. The applicant received a *quid quo pro* for abandoning his proceeding but he did not want to make that bargain. The compromise was contrary to his emphatic instructions. Although the applicant had retired from his profession, the decision against which he sought leave to appeal was of great importance to him, involving as it did conclusions that his conduct as a medical practitioner and surgeon fell short of the necessary professional standard of care. The potentially serious consequential damage to his reputation could not effectively be remedied by leaving him free to pursue any damages claim he might have against his solicitors for failing to give effect to his instructions. It is also very relevant that the applicant repudiated the compromise within hours of it being concluded and virtually immediately upon becoming aware that it bound him. The respondent did not argue that it had changed its position in reliance upon the compromise or that it would suffer any injustice other than the loss of the compromise if the compromise were not enforced. Despite the compromise and the dispute about it, both parties were ready to argue the application for leave to appeal on the day it was set down for hearing. Taken together, these considerations demonstrate that the applicant will be the victim of a serious injustice if he is denied the opportunity of having his application for leave to appeal considered by this Court.

[39] In reaching that conclusion I have not thought it appropriate to take into account my view that there is no merit in the application for leave to appeal. If the Court declined the applicant's invitation to refuse to enforce the compromise on that ground he would be afforded the inconsistent benefits of the compromise and a hearing of his application for leave to appeal. I would hold that the Court should exercise its power to refuse to give effect to the compromise so that the applicant is permitted to have the hearing in this Court which he sought when he instructed his solicitors that he did not want to compromise.

[40] The respondent argued that the Court should enforce the compromise because the applicant initially failed to make proper disclosure of the documents relating to it. The respondent correctly pointed out that the applicant initially failed to make full disclosure. Proper disclosure was made only after I concluded at an interlocutory hearing that the applicant's partial disclosure was potentially misleading and ordered further disclosure,[20] and after the respondent issued a subpoena to the applicant's former solicitors. I accept that the respondent identified some initial non-disclosures which were not insignificant, but the evidence did not establish that any particular non-disclosure was either deliberate or critically important. I am not persuaded that the applicant's initial non-disclosures constitute a ground for failing to exercise the power to refuse to enforce the compromise.

[41] I would refuse the respondent's application. Nevertheless the respondent should have its costs of its application, including reserved costs, because the applicant

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[20] *Broadbent v Medical Board of Queensland* [2010] QCA 311.

sought an indulgence and it was not until the eve of the hearing that he complied with his obligation to make proper disclosure of the relevant communications.

Application for leave to appeal

[42] I have had the advantage of reading the reasons of Chesterman JA. For those reasons the application for leave to appeal should be refused with costs.

[43] **CHESTERMAN JA:** The background to this application appears in the reasons for judgment of Fraser JA, who has concluded that the applicant should not be held to the compromise made by his solicitors by which he agreed not to prosecute his application for leave to appeal. I accept the correctness of that conclusion which makes it necessary to consider the merits of the application. In these reasons I will refer to QCAT as constituted for the purposes of the hearing of the Referral Notices concerning the applicant as "the Tribunal".

[44] It is important to emphasise that the applicant challenges the Tribunal's findings of fact, or some of them. In this case it was neither feasible nor appropriate to hear the application and the appeal together. The application properly proceeded on the basis that the applicant had to demonstrate substantial grounds for concluding that the Tribunal had mistaken facts relevant to its determination, that the applicant had behaved in a way that constituted unsatisfactory professional conduct in his treatment of two patients, Mrs MacLeod and Mrs Pearce.

[45] There are two reasons for insisting upon the separate hearing of an application for leave to appeal. The first is that the statute separates the steps. Section 149(2) of the *Queensland Civil and Administrative Tribunal Act* 2009 ("the QCAT Act") provides for a right of appeal against the decision of the Tribunal where, as here, it was constituted by a judge. By s 149(3)(b) where the appeal is on a question of fact, or a question of mixed fact and law, the appeal lies only if the Court of Appeal gives leave. In the event that leave is given the appeal proceeds by way of rehearing: s 154(2). Sometimes it will be appropriate to hear the application for leave and the appeal together. That will not be an appropriate course where, as here, there is a general attack on numerous findings of fact and no identification of particular error.

[46] The second reason for separating the hearings is that when conducting disciplinary proceedings against a medical practitioner the Tribunal which makes the determination is a specialist one.

[47] The Tribunal consisted of a District Court Judge who sat with two specialist medical practitioners and a teacher. The findings of fact of such tribunals are conventional by accorded particular respect. The approach was expressed in *Fletcher v Queensland Nursing Council* [2009] QCA 364 at [86]:

> "The Tribunal is a specialist one. Its expressions of opinion that conduct does or does not amount to unsatisfactory professional conduct should be given considerable weight and not disturbed in the absence of demonstrated error in the process of reasoning, or fact finding, or the application of the statutory definition to the facts. This I understand to be the orthodox approach to appeals from specialist tribunals. See eg *Medical Board of Queensland v Thurling* [2003] QCA 518 at [12] and *Bhattacharya v General Medical*

> *Council* [1967] 2 AC 259 at 265 in which the Privy Council thought that an appellate court should be 'slow to differ' from such a tribunal. I do not understand that *Graham v Queensland Nursing Council* [2010] 2 Qd R 157 is to any different effect."

[48] Leave to appeal will not be given because an applicant asserts that the findings were wrong, or should have been different. The applicant must identify the error or errors complained of with some particularity and show why, by reference to specifically relevant evidence, the Tribunal has made a mistake or at least arguably so. Moreover the facts which are challenged must have actually or potentially affected the determination which the applicant wishes to overturn. Incidental errors of fact will not ordinarily justify a grant of leave to appeal.

[49] The applicant appeared for himself and suffered the usual difficulties experienced by litigants in person. He was not, of course, without intelligence and had the added advantage of having studied law and been admitted to practice as a barrister.

[50] The applicant practised for many years as a general surgeon. In particular he specialised in bariatric surgery as a means of addressing morbid obesity. The operations he performed on Mrs MacLeod and Mrs Pearce were described by Dr Cohen, the applicant's expert, as:

> "… **Bilio-pancreatic bypass with duodenal switch** and **cholecystectomy** … . The essential components of this surgery involved a parietal resection of ¾ of the greater curve side of the stomach leaving her with a narrow lesser curve gastric tube. The duodenum was then divided at its junction between 1st and 2nd parts and a cholecystectomy performed. The small bowel was then measured out and divided at approximately its mid point … . The distal half of the small bowel was anastomosed to the proximal duodenal stump and the more proximal portion of jejunum was brought down and anastomosed side to side to the terminal ileum 65 cm from the ileocaecal valve. This produced a common channel 65 cm over which the food stream meets the enzyme stream coming from the jejunal (biliopancreatic) limb."

[51] According to Blakiston's Gould Medical Dictionary 3rd Edition, an anastomosis is:

> "2. A surgical communication made between … two hollow organs or by two parts of the same organ (as between the jejunum and stomach …"

[52] The Referral Notices instituted by the Board in relation to both patients alleged that there were grounds for disciplinary action against the applicant pursuant to s 124(1)(a) of the *Health Practitioners (Professional Standards) Act* 1999 in that he:

> "… behaved in a way that constitutes unsatisfactory professional conduct in that (he had) engaged in:
>
> - Professional conduct that is of a lesser standard than that which might reasonably be expected of the (applicant) by the public or … professional peers; and

- Professional conduct that demonstrates incompetence, or lack of adequate knowledge, skill, judgment or care, in the practice of the (applicant's) profession."

[53] Mrs MacLeod was admitted to the Allamanda Private Hospital on 16 June 2003 to undergo biliary pancreatic diversion bypass surgery. She was discharged on 26 June 2003. Her recovery did not go as expected and Mrs MacLeod was re-admitted to the hospital, under the applicant's care, on three occasions:

(a) 28 June 2003 to 30 June 2003

(b) 13 September 2003 to 25 September 2003

(c) 2 October 2003 to 15 October 2003

On the occasion of the last admission she was severely malnourished. She died on 15 October 2003 from septicaemia and renal failure brought on by her extreme state of malnutrition. She suffered horribly before she died.

[54] The Notice in relation to Mrs MacLeod set out seven instances of unsatisfactory professional conduct with respect to each of which detailed particulars were given.

[55] Much of the Board's case against the applicant was not made out to the satisfaction of the Tribunal which expressed itself unsatisfied with the Board's evidence in relation to several of the instances and many of the particulars. Those with respect to which the Board was satisfied that the applicant had engaged in unsatisfactory professional conduct were:

"**4. Dr Broadbent failed to provide or prescribe appropriate and adequate nutritional advice, management and treatment.**

Particulars

4.1 The advice provided by Dr Broadbent with respect to the meal size following biliary pancreatic diversion surgery was inappropriate, as follows:

(a) The pre-operative consent form utilised by Dr Broadbent stipulated for consumption of no more than 3 meals per day at a size of 50mls during the 'weight loss phase';

(b) The food consumption/meal size recommended in the consent form by Dr Broadbent was insufficient to provide for adequate nutrition.

…

4.3 Dr Broadbent failed to ensure that Mrs MacLeod was provided with adequate nutrition during the September admission, as follows:

(a) During the entirety of the September admission the records reveal that negligible food and or fluid were provided to and/or consumed by Mrs MacLeod;

(b) Mrs MacLeod was not prescribed by Dr Broadbent vitamin, iron or calcium supplements during the September admission;

(c) Mrs MacLeod's consumption of protein, during the September admission, was inadequate.

4.4 Dr Broadbent failed to ensure that Mrs MacLeod was provided with adequate nutrition during the October admission, as follows:

(a) Mrs MacLeod's oral food intake during the period of hospitalisation was inadequate to sustain long term health;

(b) Dr Broadbent failed to institute an adequate oral feeding regime and/or nasoenteral feeds;

(c) Dr Broadbent failed to institute adequate parenteral nutrition – lipids and fat-soluble vitamins being withheld;

(d) Dr Broadbent failed to assay and replace Mrs MacLeod's vitamins and minerals.

….

4.6 Dr Broadbent failed to monitor (by assaying or ordering and considering an appropriate number of tests) during the period 13 June to 13 October 2003, the following levels for Mrs MacLeod:

(a) Vitamin A;

(b) Vitamin D;

(c) Zinc; and

(d) Parathyroid hormone levels.

4.7 Dr Broadbent failed to recognise that by the September admission Mrs MacLeod was malnourished.

…

5. Dr Broadbent failed to facilitate appropriate cover for Mrs Ursula MacLeod for the period 11 October 2003 to 12 October 2003 whilst he was absent in Sydney.

Particulars

5.1 At the material times Mrs MacLeod was admitted under Dr Broadbent's care.

5.2 Dr Broadbent was responsible for the co-ordination of Mrs MacLeod's health care.

5.3 Dr Broadbent:

(a) attended on Mrs MacLeod at 0630 hours on 10 October 2003;

(b) next attended on Mrs MacLeod at 2000 hours on 12 October 2003;

5.4 During the period 11 October 2003 to 12 October 2003 Dr Broadbent attended a conference in Sydney.

5.5 There is no record in Mrs MacLeod's medical file, to the effect that Dr Broadbent had arranged to hand over to an appropriately qualified medical practitioner the co-ordination of Mrs MacLeod's medical care for the period 11 October 2003 to 12 October 2003.

5.6 No written directive or order was given to the nursing staff by Dr Broadbent to the effect that he had arranged for another appropriately qualified medical practitioner to co-ordinate Mrs MacLeod's medical care in his absence.

5.7 By virtue of 5.5 to 5.6, no appropriate handover of Mrs MacLeod's care occurred prior to his absence.

5.8 Dr Kay attended on Mrs MacLeod on 11 and 12 October 2003 and Dr Renton attended on Mrs MacLeod on 12 October 2003.

5.9 Both doctors attended in a consultative capacity only, neither having been asked to or consented to assume a co-ordinating role in relation to Mrs Macleod's health care.

…

6. Dr Broadbent failed to co-ordinate Mrs Ursula MacLeod's pain management during his absence in Sydney.

Particulars

…

6.6 Dr Broadbent failed to:

(a) adequately monitor or cause to be monitored, Mrs MacLeod's deteriorating condition during the period 10 October 2003 to 12 October to ensure that Mrs MacLeod was provided adequate pain relief during the period 10 October 2003 to 12 October 2003;

(b) investigate the causes of Mrs MacLeod's increasing levels of pain during the period 10 October 2003 to 8.00pm 12 October 2003;

(c) organise or request, following the telephone call of 1545 hours on 12 October 2003, another practitioner to review Mrs MacLeod's pain management in his absence;

(d) afford Mrs MacLeod the opportunity to discuss with him her condition and the management of her pain.

7. Dr Broadbent failed to arrange referrals when necessary to other specialists to assist in the investigation of Mrs Ursula MacLeod's deterioration.

…

7.4 Dr Broadbent failed to seek advice from a dietician or nutritionist with respect to the adequacy of Mrs MacLeod's nutritional intake."

[56] The Tribunal undertook a detailed and comprehensive analysis of the evidence before making its findings. The evidence in support of or opposition to the particulars was rehearsed and the findings expressed in a way which makes the reasons for judgment self contained. The thoroughness of the exercise undertaken by the Tribunal presents a difficulty for the applicant.

[57] The Tribunal's findings with respect to instance 4 were:

"**4.4 October admission – malnutrition**

[71] Mrs McLeod was admitted on 2 October in a malnourished state. She was 'admitted because of her nutritional needs' (T10-38 Bryceson). TPN (total parenteral nutrition) was commenced on 5 October. Dr Broadbent intended that TPN commence on admission (it was not intended that the patient's nutritional needs be provided orally) but the central line could not be inserted until 5 October due to coagulopathy (see T7-25, T16-61). The oral food/fluid balance charts for this admission indicate minimal oral food intake (ex15, Vol 2, pgs 434-441) but while waiting for the central line to be placed Dr Broadbent said (T16-67) a peripheral intravenous line was inserted and the patient was commenced on intravenous fluids and a clear fluid diet. Nasoenteral feeding was not instituted. Whether this should have occurred depends on when the patient's coagulopathy was expected to be resolved – sooner rather than later. Be that as it may Mrs McLeod should have, but wasn't, provided with adequate nutrition between 2 and 5 October. Dr Cohen said (T13-29) that it was during this period that the experts considered (ex 2) that Mrs McLeod was not getting enough nutrition. In evidence (T14-42, 43) he

initially agreed that there were alternative ways to provide nutrition while awaiting the start of TPN. This was also the view Dr Woods expressed in evidence. I cannot accept Dr Broadbent's contention (T17-18) that 'an adequate oral feeding regime' was in place. I cannot accept his evidence (T16-66, 67) that by not starting TPN because of the patient's coagulopathy the intensivists 'assessed her nutritional situation as not being desperate or really serious.' They did nothing of the sort. Their decision was only that TPN could not be started on admission because of coagulopathy.

[72] TPN was commenced on 5 October by the intensivists. In ex 65 Dr Broadbent said:

> "301 As the co-ordination of the management of Mrs MacLeod was accepted by the Intensivists, my role was now considerably reduced, however I continued to monitor progress during my daily rounds and as and when I was provided with results by ICU and other doctors.
>
> 305 On 5 October 2003 I referred Mrs MacLeod to Dr Allan Parnham, Consultant Nephrologist for the management of incipient renal failure and Dr Parnham accepted that role, assessed Mrs MacLeod and annotated the chart. The involvement of a second managing physician further reduced my involvement.
>
> 399. Dr Broadbent's co-ordinating role was taken over by Intensivists on 2 October 2003 and they were further assisted by Dr Parnham on 5 October 2003.
>
> 400. ICU Intensivists and Nephrologists were in a treating capacity – hence they initiated investigations, charted drugs and fluids, inserted catheters and replaced them, and gave general orders regarding Mrs MacLeod's treatment."

The intensivists did not in fact become involved until TPN began on 5 October.

[73] In the period before the intensivists took over Dr Broadbent maintained there was an adequate oral feeding regime and nasoenteral feeding was not required (T17-17). I am unable to agree that this was so nor can I accept the 'revised evidence' Dr Cohen later gave. The preponderance of evidence suggests inadequate provision of nutrition.

[74] Dr Cohen said (T13-28) that he did not think a delay of about 3 days before TPN was commenced 'made any difference at all to her outcome'. He also said that it was not Dr Broadbent's fault that TPN had to be delayed and that is

so. He agreed though (T13-29) that ex 2 contained a 'statement of fact' that before TPN was commenced Mrs MacLeod 'was not getting enough nutrition'.

[75] When TPN was commenced lipids were withheld. Lipids would normally be included in parenteral nutrition. The hospital notes give the impression that this was at the direction of Dr Broadbent (ex 15, Vol 2, pg 376). Dr David Stephens, one of the intensivists, said this occurred 'by consultation' and 'she was on some oral intake anyway' (T12-40). Dr Broadbent said (T16-12,13) that he 'asked the intensivists to consider omitting lipids from the mixture' and discussed why; the intensivists made their own decision. It is not necessarily the case that this meant that Mrs MacLeod's nutritional intake was, as a result, inadequate.

…

[82] In evidence Dr Cohen again changed tack. He seemed to say that the views in ex 2 were based on a 'standard post operative testing regime' and he said the experts couldn't ascertain what Dr Broadbent's testing regime was leading up to the October admission (T13-33). He then said (T13-33, 34) that by 2 October Dr Broadbent had requested 'an appropriate panel of tests' (zinc and vitamin A) and vitamin D and parathyroid hormone were not required at that time (even though vitamin D had in fact been assayed on 1 October) – they were more related to low metabolism, rather than renal or liver function. He did say though that he himself would, at the September admission, have ordered 'a panel of nutritional indices including vitamin A and zinc and vitamin D'. This is consistent with what Prof Woods said (T3-19, 20). Prof Woods conceded some variation between individual doctors as to exactly what is assayed and the frequency of it. As to vitamin D he said that in addition to its role in controlling calcium levels it is also necessary for the immune system and along with vitamin A is vital 'for good health'. He also said (T3-18) that parathyroid hormone levels were assayed

> 'in an effort to ensure that the patient is not, if you like, cannibalising her bones for calcium.'

[83] Ms Williams also said that given Mrs MacLeod's symptoms post-surgery, testing only in October would not have been adequate; she would have arranged for tests about 2 months post-operatively (T4-20).

[84] Dr Broadbent's response (T17-18) that assaying vitamins and minerals on 2 October was 'all we could do' is not sufficient.

[85] In my view the opinion expressed in ex 2 more accords with what I consider should have been done. Monitoring only on

one occasion and then only of vitamins A and D and zinc was not sufficient.

4.7 Failure to recognise that patient was malnourished by September admission

[86] The experts agreed she was developing malnutrition by this time and that Dr Broadbent appeared not to realise this.

[87] Prof Woods said (T3-41) that by the time of her September admission she was 'grossly protein deficient' and her rate of weight loss was 'double what one would expect'. Also her albumin level on 13 September (requested by Dr Broadbent) was low (ex 15, Vol 2, pg 218, T6-55, 56).

[88] Dr Cohen agreed (T13-3, 39) that her low protein state 'probably reflected a patient who was not getting adequate protein, particularly nutrition' and she was probably developing malnutrition by the September admission and this was not then appreciated or recognised by Dr Broadbent. He further said that on the available evidence presented to him Dr Broadbent should not have recognised it.

[89] Prof Woods said the basis of the opinion expressed in ex 2 was that a dehydrated patient with low albumin (which Dr Broadbent 'set about supplementing intravenously) and a history of 2 - 3 weeks vomiting pre-admission was likely to be malnourished (T6-54, 55, 56).

[90] In my view it is implicit in Prof Wood's evidence that when he said the experts agreed Dr Broadbent appeared not to realise this, they meant also that he should have and I am unable to accept the different view expressed by Dr Cohen in evidence. In my view the objective evidence more supports the view expressed in ex 2 and the evidence of Prof Woods.

[91] Dr Broadbent's statement (T16-110) that Mrs MacLeod was not malnourished was not really responsive to the allegation that she was then developing malnutrition and in any event I am satisfied that she was at least developing malnutrition, if not malnourished in fact, and that he should have recognised this."

[58] The second instance of unsatisfactory professional conduct concerned the applicant's absence from the Gold Coast to attend a conference in Sydney over a weekend when Mrs MacLeod was in hospital, gravely ill, in October 2003.

[59] About this the Tribunal said:

"5.7 No appropriate handover?

[102] What is alleged here is that by reason of **paras 5.5** and **5.6** (which are admitted) there was no appropriate handover of

care during Dr Broadbent's absence in Sydney. In fact there was no handover and there should have been; Dr Broadbent remained in charge albeit in Sydney (just like Dr Cohen said he was still in charge of his patient in Perth while giving evidence at Southport, contactable by phone. Dr Cohen conceded however that staff in Perth knew where he was and was not, and that in the case of a patient of his who was in hospital, he rang in the morning and asked how she was going T13-42) (**para 5.7**).

[103] Dr Broadbent didn't, when he left for Sydney, know that Dr Rutherford was the on call surgeon rostered for the weekend and he didn't contact him prior to going to Sydney because there were, he said, no active surgical issues and Dr Rutherford had no experience with BPD patients (T17-36,37,75-76). Mr Hackett conceded that Dr Rutherford wasn't contacted before Dr Broadbent went to Sydney (T18-73). Dr Rutherford was the on-call surgeon because it was his turn on the roster not because Dr Broadbent had specifically arranged for him (T16-75,76). Dr Broadbent didn't know or enquire which surgeon would be available in his absence.

…

[104] Dr Broadbent's intention was that, if it was considered necessary by staff at Allamanda Private Hospital, he was to be telephoned in Sydney; the first call was to be to him. He said that before leaving he advised the ward sister, Sharon Gough, to note his absence from the Gold Coast and to call him first if his input was required 'and so I could brief Dr Rutherford if surgical intervention be needed whilst I was away' (ex 65 para 369).

[105] Nurses on the ward were aware that Dr Broadbent was away in Sydney and that he was to be contacted by phone if needed (Nurses Nuttall T4-61, 62 and Sellars T7- 13). This also supports the conclusion that Dr Broadbent remained in overall charge of the patient's care while in Sydney.

…

[107] Dr Broadbent was attempting to co-ordinate, as required, Mrs MacLeod's medical care by phone from Sydney. Dr Renton, Dr Kay and Dr Seeley were not coordinating Mrs MacLeod's health care (**para 5.9**).

[108] The issue is whether Dr Broadbent could adequately co-ordinate care from Sydney. Prof Woods thought he should have formally arranged someone local to cover for him and formally advised the hospital of this (T3-45). In his opinion 'it is not possible to co-ordinate when you're interstate': …

[109] Dr Cohen thought that the fact that Dr Broadbent was contactable by mobile phone meant that he did retain an appropriate level of co-ordination (T13-42).

…

[111] Dr Broadbent's response to the handover provisions of the Code of Conduct for Doctors in Australia (ex 61, para 4.3) was that he had not transferred all responsibility to another doctor and that is clearly so.

…

[113] Mrs MacLeod's condition was clearly deteriorating over the weekend 'with progressive sepsis and thrombocytopenia and deteriorating renal function' (T6-66). …

[114] In fact, when Dr Parnham handed over to Dr Kay he described Mrs MacLeod as a 'disaster' (T7-47). When Dr Kay saw her on 11 October she 'looked extremely sick'. Dr Broadbent last saw Mrs MacLeod at about 1830 hours on 10 October.

[115] Whether adequate co-ordination could be provided from Sydney obviously depends on the condition of the patient and how the patient's condition was progressing. In the case of Mrs MacLeod, Dr Broadbent knew regular blood tests were occurring and not only did he not see them, he didn't enquire about them. Dr Kay was primarily concerned with the patient's renal condition and blood tests relating to the renal function (T7-47). Dr Broadbent admitted that he did not see the blood tests results of 10 October (see para [131]). As the doctor co-ordinating Mrs MacLeod's health care he should have seen them. To an extent the intensivists were also somewhat compartmentalised in their approach.

…

[117] … In my view the patient required the physical presence of a co-ordinating doctor. Dr Broadbent was not, in my view, able to properly coordinate care from Sydney. He may have been able to do more had he enquired regularly about her condition but he didn't. He responded only when telephoned and even then he was not able to see for himself the nature and extent of the patient's deteriorating condition. In these circumstances I am satisfied that, if he could not be present he should have, but didn't arrange, for another doctor to take over his role of co-ordinating care for the patient.

[118] On the Sunday Dr Broadbent was not able to review the patient before 2000 hours because he was in Sydney and he was not able, for the same reason, to observe, monitor and deal with the obvious deterioration in Mrs MacLeod's condition over the weekend. He tried to do so to a limited extent by phone – when he answered it – but this was no proper substitute for on site physical presence where he could see the patient and properly co-ordinate her care. By

the time Dr Broadbent saw her at 2000 hours she was asleep "and settled without additional analgesia; the pain was no longer an issue for her" (ex 65, paras 398, 340). This was probably only because she was asleep not necessarily because she was no longer in pain.

[119] After seeing Mrs MacLeod at 2000 hours, Dr Broadbent 'then spoke with the relatives present, explaining the gravity of the situation…' (ex 65, para 399). He then recorded in the hospital notes 'condition has deteriorated over the last 48 hours considerably' (ex 15, Vol 2, pg 393, ex 65 para 401). Such deterioration was, I find, at least a distinct possibility over the weekend and required Dr Broadbent's continuing physical presence to attend to the patient (or a co-ordinating doctor in his place).

[120] In Mrs Macleod's case, I appreciate that issues relating to nutrition and renal impairment were medical, not surgical and both were to an extent, being managed by the intensivists and renal physicians, independent of Dr Broadbent. Also, there did not appear to be an active surgical problem over the weekend which was likely to require Dr Rutherford's involvement. It was also not intended that Dr Rutherford assume Dr Broadbent's role as the patient's health care co-ordinator. Dr Broadbent retained that role.

[121] For these reasons I am satisfied that it has been established that Dr Broadbent failed to facilitate appropriate cover for Mrs MacLeod over the weekend. He should have arranged for a doctor to be on hand on site to co-ordinate the patient's health care. Ad hoc local arrangements were not an adequate response to the patient's deteriorating condition. It was not sufficient to delegate to nursing staff the decision whether his 'input' was required or to assume other specialists would, without involvement on his part, be able to figure out what was the patient's overall condition."

[60] The efficacy of the pain management afforded to Mrs Macleod while the applicant was absent in Sydney was instance 6 in the Referral Notice. The Tribunal found the complaint to be made out. It said:

"[141] The experts agreed that the nursing notes for 11 and 12 October indicate constant complaints of pain by Mrs MacLeod and requests for analgesia: …

…

[144] I find it concerning that no doctor appears to have recorded or can recall the deteriorating physical condition of Mrs MacLeod over the weekend as observed by her daughter and recorded by the nurses.

[145] The nursing notes of 11 October, 0700 hours, record that Mrs MacLeod wished to see a doctor regarding her pain relief (**para 6.4**) (see ex 15, Vol 2, pg 388 – 'patient wants to speak to Dr. regarding need for pain relief.') She did in fact see Doctors Kay, Renton and Seeley on 11 and 12 October (and was thus afforded an opportunity to discuss her pain with a doctor) yet apparently made no mention of her pain to them (**para 6.4**).

…

[147] In my view much of this confusion would not have arisen had Dr Broadbent been on site monitoring the patient. Phone contact was intermittent (no doubt between conference sessions) and decisions about pain and general management were left to other doctors not necessarily conversant with the full picture and it was left to nurses to decide which doctors to speak to. Dr Broadbent left it to the nurses to speak to other doctors about pain relief rather than speak to those doctors himself. Had he been at the hospital he could have made the decisions himself.

[148] The renal physicians who were seeing Mrs MacLeod and the intensivists were concentrating on their respective disciplines; they were not monitoring her care as a doctor responsible for the co-ordination of that care would be expected to. Dr Broadbent said he 'made repeated telephone calls to the hospital and enquired (of) her condition' and he first learned of 'any pain change' on 12 October 'at about 2pm' (T17-22). The hospital notes refer to only one telephone contact by Dr Broadbent with nursing staff (12 Oct, 1545 hours – Nurse Nuttall). Nurse Sellars referred to one telephone call around lunchtime on 12 October (this call is not recorded but I accept that it took place). There is no other record of any contact by Dr Broadbent with the hospital, enquiring about Mrs MacLeod's condition.

[149] I am satisfied that adequate monitoring as alleged in **para 6.6(a)** did not occur. No investigations into the causes of Mrs MacLeod's increasing levels of pain were carried out by Dr Broadbent on 10, 11 and 12 October as alleged in **para 6.6(b)**. The patient complained of pain to nurses, but not doctors, and the records do not indicate advice to Dr Broadbent about pain until 1545 hours on 12 October.

…

[153] I agree with the experts that it was not practical for Mrs MacLeod to discuss with Dr Broadbent her condition and the management of her pain whilst he was in Sydney (**para 6.6(d)**). His absence in Sydney meant that between 1830 hours on 10 October and 2000 hours on 12 October (when she was asleep) he could not discuss those matters

> with her. He therefore did not afford Mrs MacLeod the opportunity to discuss with him her condition and the management of her pain."

[61] The only particular of instance 7 which the Tribunal found to have been established was particular 7.4, that the applicant failed to seek advice from a dietician or nutritionist with respect to the adequacy of Mrs MacLeod's diet. The Tribunal said:

> "[156] Dr Broadbent did not, at any time, obtain an opinion from a dietician about Mrs MacLeod's s nutritional intake; he said there was "no necessity" (T17-41).
>
> [157] The experts agreed it would have been desirable to do so (ex 2).
>
> [158] Mr Williams said that in her practice bariatric surgeons referred patients to her. She said (T4-8):
>
> > 'it's an essential part of the referral process to actually have a dietician involved in BPD and in all bariatric procedures'.
>
> [159] Such patients require more protein than someone who hasn't had the procedure (T4- 13).
>
> [160] It seemed to Ms Williams that Dr Broadbent was 'confused' about general nutrition issues (T4-15, 16 and her affidavit TW-4). She said 'a dietician needs to be involved in this sort of procedure. It's quite a significant procedure in terms of nutrition' (T4-20, 22). She said she had not met any surgeons 'who are capable of managing the nutrition/the nutritional status of their patients' (T4-23).
>
> [161] I accept the evidence of Ms Williams – it was more informed on dietary matters than was Dr Broadbent's. Because of the undoubted importance of diet and nutrition to BPD patients and the necessity for compliance by them with dietary restrictions, Dr Broadbent should, in my opinion, have sought advice with respect to the adequacy of Mrs MacLeod's nutritional intake from a dietician such as Ms Williams. This conclusion is, I consider, consistent with the opinion expressed by the experts (ex 2)."

[62] Both the applicant and the Board retained expert witnesses. Pursuant to an interlocutory order of the Tribunal the experts conferred and produced a joint report with respect to the Referral Notice for Mrs MacLeod. The Board retained separate experts for two referrals. The applicant retained the same expert, Dr Cohen.

[63] The experts' joint report, in the case of Mrs MacLeod's referral, became exhibit 2. Relevantly the experts concluded:

> "4.1 All agreed that if the dietary advice provided by (the applicant) was to consume no more than 3 meals per day of no more than 50ml during the 'weight loss phase', then

adequate nutrition, particularly the provision of protein was impossible. The advice was such that it would inevitably lead to malnutrition if it were adhered to. Furthermore, all agreed that the advice to avoid all animal products was inappropriate and would make provision of adequate nutrition even more difficult. Dr Marceau states that he does not believe that this advice could have been given by a surgeon experienced in biliopancreatic diversion.

…

4.3 All agreed that the patient was not provided with adequate nutrition during the September admission, in particular she received virtually no protein and there is no documentation that (she) received vitamin supplements, notwithstanding (the applicant's) assertion that she was self medicating with vitamins.

4.4(a) All agreed that Mrs MacLeod failed to receive adequate nutrition during the October admission until TPN was commenced.

4.4(b) All agreed that (the applicant) failed to institute an adequate enteral feeding regimen during the October admission. He had been planning to institute parenteral nutrition, but this was delayed by 3 days due to her coagulopathy on the advice of the TPN service.

4.4(c) All agreed that when the patient eventually began parenteral nutrition it was not 'total' … as lipids were withheld, apparently at the direction of (the applicant). This was considered appropriate. However, all agreed that parenteral or enteral nutrition should have been phased in gradually to avoid refeeding syndrome. Dr Cohen believed that the intravenous feeding regimen was the responsibility of the TPN team.

4.4(d) All agreed that (the applicant) should have assayed a range of vitamin and minerals prior to her October admission. Any deficiencies should have been treated prior to that time. Appropriate tests were ordered on October 1st.

…

4.7 All agreed that the patient was developing malnutrition by the time of the September admission and that the (applicant) appeared not to realise this."

[64] A second joint conference in which the expert nutritionist did not participate agreed upon the following:

"5.1 All agreed that the patient was under the care of (the applicant) on October 11th and 12th 2003.

5.2 All agreed that he was responsible for the coordination of her health care.

…

> 5.5 All agreed that there was no record in the patient's file to indicate that (the applicant) had handed over her medical care during (the time he was in Sydney). We cannot say with certainty that no such record existed 'elsewhere'.
>
> 5.6 All agreed that there was no apparent written directive to the nursing staff to the effect that he had arranged another medical practitioner to coordinate her care during his absence.
>
> …
>
> 6.6(b) We agree that no investigations of her increasing pain were undertaken by either (the applicant) or the attending physicians.
>
> …
>
> 6.6(d) We don't believe it was practicable for the patient to speak to (the applicant) personally about her pain during the time he was away.
>
> …
>
> 7.4 All agree that he failed to obtain an opinion from a dietitian with respect to her nutritional intake and all agree that it would have been desirable to do so."

[65] Given the details of the findings and the content of the experts' report it is not immediately obvious that the Tribunal erred in making the findings of fact it did. The evidence both oral and written was very extensive and consisted of far more than I have outlined. The findings indicate a careful consideration of the relevant materials and a rational acceptance of evidence. The applicant, if he were to obtain leave to appeal, had to show that the conclusions of fact could not have reasonably been made, either because there was no evidence to support its findings or that the evidence it accepted was outweighed by evidence to the contrary effect. The applicant did not attempt such an investigation or analysis. His address to the Court consisted of generalised criticisms of the findings, including those which the Tribunal made in his favour. He did not identify any particular fact or finding of fact which he claimed was wrong, nor did he attempt the task of analysing findings by reference to evidence relevant to it to demonstrate why the Tribunal might have been in error. Instead he repeated to the Court the opinions and evidence he had urged on the Tribunal.

[66] The Court repeatedly drew the applicant's attention to the task he had to essay if he were to persuade it to grant leave to appeal. Despite the admonition the applicant continued with his generalised asseverations that the Tribunal should have accepted in its entirety his opinions and his account of the facts.

[67] Given that approach it is difficult to deal sensibly with the application. The short point is that the applicant did not begin the necessary exercise of exposing factual error on the part of the Tribunal, if it existed. It was not the function of the Court to undertake the task which the applicant should have, but did not, perform and to

rehear the whole of the proceedings to see if some error of fact might be discovered. Such an approach would override the express provisions of s 149(3) and s 154(2) of the *QCAT Act*.

[68] The applicant had one recurring theme in his argument with respect to the Referral Notice in relation to Mrs MacLeod. It was that Mrs MacLeod's malnutrition and consequent death was caused by her drinking substantial quantities of a herbal tea containing senna. This was said to act as a laxative and so decrease further the capacity of Mrs MacLeod's surgically reduced stomach to absorb nutrition. The applicant further contended that Mrs MacLeod concealed the fact that she was drinking senna in large quantities and that he was in no way at fault in not understanding the cause of her malnutrition or in being able to treat it. He submits that the Tribunal overlooked this important evidence which falsifies its entire approach to the proceedings in respect of Mrs MacLeod.

[69] The applicant's written submission contained this:

> "**Failure of Simple Logic**
>
> The Tribunal failed to apply the logic that:
>
> > If the Senna Tea caused the diarrhoea (as was decided)
> >
> > and
> >
> > If the diarrhoea caused the malnutrition, dehydration and renal impairment
> >
> > Then
> >
> > The evidence that the operation was at fault for the diarrhoea fails
> >
> > The evidence that Dr Broadbents (sic) advice was at fault (as I see) for malnutrition fails
> >
> > That the evidence that the vitamin and protein introduction testing was delayed fails
> >
> > That the cause for Mrs MacLeods (sic) hospitalisation fails
> >
> > The persistent occurrence of in-hospital diarrhoea and vomiting failes (sic)
> >
> > That the requirement for special investigation fails
> >
> > The issue regarding in hospital feeding failed
> >
> > The need for all else fails
> >
> > The readmission in October occurred because of the same senna tea
> >
> > The insertion of a CV line was appropriate

> And the referral to other managing physicians was appropriate
>
> And
>
> The matter should have ended there, as the remainder was the responsibility of the managing intensivists and renal physicians and clinical haematologist."

[70] The applicant's oral submissions were to the same effect, and repeated the same claims. What the submission overlooks is that the Tribunal dealt at length with the contested question of fact whether Mrs MacLeod did or did not drink herbal tea with senna. Her daughter said she did not but there was evidence that she did. Having reviewed the evidence the Tribunal found that its preponderance supported the intake of senna, which did operate as a laxative, and that Mrs MacLeod's attitude "to compliance with (the applicant's) dietary regime" was "casual".

[71] The complaint that the Tribunal ignored Mrs MacLeod's consumption of senna is wrong. So is the applicant's "logic" that the ingestion of senna absolved him from responsibility for Mrs MacLeod's care which the Tribunal found fell short of professional competence.

[72] The fact that the herbal laxative exacerbated the patient's inability to absorb food did not exonerate the applicant from failing to observe, as the Tribunal found he did, that Mrs MacLeod was showing signs of malnourishment during her September admission to hospital. She was admitted a month later gravely ill from malnutrition. That a cause of malnutrition was unknown was irrelevant. She should have been treated appropriately for malnutrition. The Tribunal found she was not. An unknown cause of malnutrition did not excuse the applicant leaving the patient without arranging for a co-ordinating physician to be responsible for her care while he was in Sydney. It did not explain why her pain was not managed appropriately.

[73] In a supplementary submission delivered to the Court, without permission, after the conclusion of the hearing the applicant contended that Mrs MacLeod "did take the Herbal Tea" before he and she made their contract by which he agreed to perform the surgery, and that:

> "The Tea had a major impact on the effects of the operation in that it … induced the increased level of malnutrition, such conduct … voids the contract. … In these circumstances (the applicant's) function was reduced to that of any "Good Samaritan" Doctor carrying out emergency treatment, where the causal factors of an illness remain unknown."

[74] The submission is misconceived. The contract between the applicant and his patient was not avoided. It was fully performed. The contract is irrelevant to the applicant's obligation to provide professionally competent care in the respects just discussed. The ingestion of senna may have made diagnosis and treatment more difficult but did not absolve the applicant from treating Mrs MacLeod with professional diligence. In any event, what distinguished the good samaritan from the priest and the levite was that he stayed with the wounded traveller. He did not leave to attend a conference.

[75] The applicant has not shown any reason why he should be given leave to appeal against the Tribunal's findings with respect to Mrs MacLeod.

Mrs Pearce

[76] The Referral Notice with respect to Mrs Pearce alleged, in its final form, four instances of unsatisfactory professional conduct. Those found by the tribunal to have been made out were:

> "**14. Dr Broadbent failed to diagnose and treat Mrs Pearce's anastomotic leak.**
>
> **Particulars**
>
> …
>
> 14.4 Dr Broadbent:
>
> (a) did not give, and/or did not document that he gave, any consideration to a diagnosis of anastomotic leak;
>
> (b) failed to undertake, or cause to be undertaken, any investigations to exclude anastomotic leak and/or establish the cause of Mrs Pearce's symptoms, namely:
>
> (1) Dr Broadbent failed to undertake chest x-rays, abdominal x-rays or CAT scans of the abdomen.
>
> …
>
> **19. Dr Broadbent carried out an upper gastrointestinal endoscopy when it was inappropriate to do so.**
>
> **Particulars**
>
> 19.1 Mrs Pearce was suffering with symptoms consistent with anastomotic leak and/or small bowel perforation and/or intra abdominal abscess formation:
>
> (a) the Registrant's Board repeats and relies on the matters set out in paragraphs 14.2 and 14.3 herein.
>
> 19.2 Upper gastrointestinal endoscopy is contraindicated for persons suffering anastomotic leak and/or small bowel perforation and/or intra abdominal abscess formation as it carries with it the risk of further rupture of the bowel and/or the rupture of the abscess into the peritoneal cavity.
>
> **20. Dr Broadbent's management of Mrs Pearce contributed to her death.**
>
> **Particulars**
>
> 20.1 The Registrant's Board repeats and relies on the matters set out at paragraphs 14, 16 and 19 herein."

[77] The applicant performed bariatric surgery on Mrs Pearce on 27 March 2000. She was discharged from hospital on 4 April 2000 but readmitted under the applicant's care on 10 April. Seven days later the applicant performed an upper gastrointestinal endoscopy. Mrs Pearce died during the procedure from cardiac arrest.

[78] The Tribunal found:

> "**14. Diagnosis and treatment of anastomatic leak**
>
> **Was there such a leak?**
>
> [164] The experts (ex 3, para 14) agreed there was – at the duodeno-ileal anastomosis.
>
> [165] Fundamental to the allegation that there was such a leak is Dr Broadbent's own record of the gastrointestinal endoscopy he was performing when Mrs Pearce died (ex 16, pgs 70 & 81 and ex 68, pg 13). He recorded the presence of a pseudodiverticulum adjacent to the duodeno-ileal anastomosis showing what looked like a leak from the tip of the pseudodiverticulum. …
>
> …
>
> [167] In his statement to the police dated 19 April 2000 (ex 16, pg 26 and ex 66, para 57) Dr Broadbent said:
>
> > 'The gastroscopy proceeded uneventfully, the findings at gastroscopy were the oesophagus and stomach were normal, as was the anastomosis at the neo duodenum, but there was a pseudo diverticulum of the duodenum with evidence of a contained leak. It appeared that this may have penetrated into the peritoneal cavity, and an apparent aperture was dilated. The next intention was to pass a drain into this area, but at that point Dr Phillip Harrington the Anaesthetist advised me that Maggie's breathing was becoming laboured and I withdrew the gastroscope so that Dr Harrington had full and free access to the airway.'
>
> [168] Dr Cohen agreed in evidence that the nature of the leak was a contained one (T13-69). Prof Wall is convinced there was 'a leak of some kind' (T11-21).
>
> [169] In paras 62-65 of ex 66, when responding to the reports of Prof Wall ex 42, Dr Broadbent appears to contradict what he recorded in his operation notes and in his police statement. He said:
>
> > '62. I disagree with Professor Wall's assessment in which he states there was a pre-existing anastomotic leak (presumably at the gastro-neoduodenol anastomosis) which I should have recognised earlier and not done a gastroscopy.

63. The pseudo-diverticulum was small, and created to a large extent by my passage of the scope into it and was contained within the root of mesentery of the transverse colon. The defect was not draining into the peritoneum and thus not causing any signs of peritonism.

64. The defect may not have been noticeable on a CT scan and possibly not on gastrografin meal.

65. In any event, I made the defect aperture larger with the scope. It contained no fluid or debris or food contents. Such could and should not be characterised as a "pre-existing anastomotic leak". It was a defect but it was not leaking and it might have gone unnoticed but for the gastroscopy.'

[170] His evidence was to the same effect. I considered his evidence (T16-94, 95) that he did not in fact find evidence of a contained leak (contrary to what he said in his statement to police), that it had only the appearance of a contained leak and that what he 'assumed to have been evidence of an anastomotic leak was not an anastomotic leak' to be quite disingenuous.

[171] He explained his police statement that there was 'evidence of a contained leak' as being his interpretation (now said to be incorrect) of what the pseudodiverticulum was at the time (T16-96). He said (T16-95) that when he referred to the pseudodiverticulum as evidence of a contained leak he was merely 'trying to be helpful'. I cannot accept this evidence; it was an attempt to explain away why he did not undertake appropriate radiological investigations before considering an intrusive investigatory option such as a gastroscopy. He conceded though that he has 'very little detailed recollections' (T16-95) and has 'few detailed personal recollections of Mrs Pearce's time on the ward' (ex 67, para 38). His evidence seemed to be dependent on an examination of 'the records' (ex 67, para 39) and subjectively favourable ex post facto interpretation.

[172] Dr Broadbent said that when he spoke of a 'contained leak' he meant that there was a 'leak' but it was contained within the boundaries of the pseudodiverticulum (and was not leaking into the peritoneum). He said that 'when I was looking at it, it just popped' (T16-107). This evidence is consistent with what he said in paras 62-65 of ex 66 but inconsistent with his operation record and his police statement.

[173] In these circumstances I am also unable to accept the evidence of Dr Broadbent that the possibility of a gastric or anastomotic leak had been considered by him and

discounted (T16-99). In my view it's likely that he overlooked or didn't advert to the possibility of such a leak. Alternatively he misinterpreted the symptoms exhibited by the patient. I also think that after the discharge of 800 mls of bile stained fluid stopped he failed to advert to the possibility that it could be collecting inside. The matters he listed in ex 67, para 74 are, I consider, an attempt to justify in hindsight what was not properly considered in the first place. He may also have failed to appreciate that the discharge of 800 mls could have in fact delayed deterioration in her condition by relieving or reducing the amount of interior contamination. This scenario was referred to by Prof Wall at T11-9 and I accept it could have been why Mrs Pearce did not, at least initially, deteriorate to the extent Dr Broadbent said he would have expected in the case of a patient with, or possibly with an anastomotic leak. Prof Wall said (T11-14, 15) "the discharge of the bile was alarming and the fact that it didn't continue was even more alarming … in the sense that it was probably collecting inside, drains aren't perfect ..." On 15 April there was a further discharge of 100 mls and 20 mls subsequent to that which supports the existence of a leak (T11-17).

…

[175] In my view there was in fact an anastomotic leak and in this respect I prefer the contemporaneous statements of Dr Broadbent to statements made by him many years later responding to the allegations made in the Amended Referral Notice. In these circumstances Prof Wall was correct in concluding that there was in fact an anastomotic leak.

[176] Dr Broadbent conceded that if there was in fact an anastomotic leak he failed to undertake appropriate radiological investigations (T16-95). …

[177] I appreciate that a finding that there was an anastomotic leak is at odds with the findings at post-mortem of Dr Catherine Downes (ex 44 and ex 60, para 17(a)) and the evidence given by her, but I am unable to accept her evidence. I think she is mistaken in her conclusion about the absence of any post-operative anastomotic leak. In this respect I am comforted by the fact that the experts effectively reached the same conclusion in ex 3.

…

[179] I agree with the conclusion and reasons of Prof Wall that Dr Downes' post-mortem finding in this respect is unreliable and wrong. Prof Wall said at (T11-23, 24, 25, 31 and 32):

> 'However, opening the abdomen after previous surgery is an extremely challenging task, even a surgeon

himself may have difficulty interpreting the findings, and to highlight that the report suggests liver and the gall bladder are normal, yet we know Dr Broadbent removed the gall bladder so it raises doubt about the depth of understanding of the pathologist at the time. …'

…

[181] **Para 14.4** I am satisfied that Dr Broadbent did not advert to the possibility of an anastomotic leak and therefore did not undertake investigations of the type referred to in **para 14.4(b)** of the Amended Referral Notice. Nothing is recorded in the hospital records indicating that he considered the possibility of an anastomotic leak. In my view he should have and in this respect I again accept the evidence of Prof Wall. The conclusion he and Dr Cohen reached in ex 3 is that Dr Broadbent should have undertaken appropriate radiological investigations to exclude an anastomotic leak or establish the cause of Mrs Pearce's symptoms referred to in **para 14.3** of the Amended Referral Notice and I accept what they say. In evidence Dr Cohen reiterated his agreement with the conclusion reached by him and Prof Wall in ex 3 (T13-69, 70).

[182] The fact that Mrs Pearce in fact did exhibit the symptoms outlined in **para 14.3** is referred to in the report of Prof Wall dated 26 February 2008 (ex 42) and in his evidence (T11-9). It was not put to him that she did not exhibit those symptoms.

[183] Dr Cohen agreed that the chief clinical signs raising the possibility of a leak were the proximity of symptoms so close to surgery, the development of a fever, a tachycardia and a high white cell count and possibly vomiting (T13-70).

[184] Prof Wall said in evidence:

- the symptoms exhibited by Mrs Pearce post operatively were such as to require Dr Broadbent to consider the possibility of an anastomotic leak (T11-9)

…

- the 'discharge of the bile was alarming and the fact that it didn't continue was more alarming… in the sense that it was probably collecting inside;… if it doesn't keep coming you've got to say to yourself why – has it healed or is it collected inside' (T11-14, 15)
- interpreting physical signs at the bedside of a patient such as Mrs Pearce is 'inherently

dangerous;… the way to exclude a leak is either an x-ray, a CT or a gastrografin meal study' (T11-18, 20)

…

- there was 'a leak of some kind in this patient;… the observations of Dr Broadbent, the history of the patient progress and the appearance of discharge from the abdominal drain which contained a large number of pathogens all add up to evidence to support the leak from the abdominal track. These phenomena don't occur spontaneously from the abdomen;… they are indicators or evidence supporting a leak, they could be supportive of something else but you need to at least give her the dye or something like that just to see what it is' (T11-21)
- 'in this instance there were two possibilities, one a generalised leak and the second a localised leak' (T11-27).

I accept this evidence; it is supported by the fact, as I have found, that there was in fact an anastomotic leak. For the same reasons I accept the following opinions of Prof Wall in his report dated 26 February 2008 (ex 42): …

[185] The presence of bile in the drain in the gall bladder bed may or may not be indicative of an anastomotic leak. I cannot accept Dr Cohen's evidence that it cannot be indicative of such a leak. In any event I consider that the presence of bile or bile stained fluid coupled with the failure of Mrs Pearce to progress warranted investigations of the nature suggested by Prof Wall and if they had been carried out I am satisfied that they would have indicated a leak at the duodeno-ileal anastomosis. … Dr Broadbent admitted that Mrs Pearce was exhibiting some 'abnormal signs' – 'a fluctuant temperature and a bile stained discharge'. He said he 'considered they were connected and were from the same pathology, namely a persisting bile leak in the gall bladder bed of the liver' (ex 66, para 71) but in my view he could not, without tests, exclude an anastomotic leak. In other words he could not, without tests, be certain of the source of the discharge. …

[186] Dr Broadbent conceded it is reasonable to adopt an approach of continued suspicion and important that opportunities to help be not missed (T17-10). Relevant investigatory mechanisms were available on the Gold Coast at the time (see also T16-106). If there were a leak he agreed with the evidence of Prof Wall as to how to treat it (T16-104). 800 mls of bile stained fluid is recorded as having "oozed from the site" on 11 April 2000 (ex 16, pg

63) Dr Broadbent conceded that if that were so "it would be of concern" (T16-93).

…

[188] The result is that I accept the submission of MBQ (ex 70, para 171) that:

> 'it was incumbent on the Registrant to attempt to exclude the critical diagnosis of anastomotic leak utilising the least invasive investigations available before submitting Mrs Pearce to not only an invasive procedure requiring anaesthesia but one which was contraindicated in the presence of (possible) anastomotic leak.'

This is based on the evidence of Prof Wall. In addition to what I have already referred to he said:

- 'the important burden on the surgeon is to disprove a leak and I don't believe that pathway was taken, another pathway was taken to find the mechanism of blockage in the upper gastrointestinal tract' (T11-22)
- 'In Mrs Pearce's situation, I believe she was progressing. I believe we would have not operated. We would have imaged and repeatedly checked for collections inside her abdomen which were making her sick and then intermittently drained those. We might have even done a small operation to facilitate the drainage... I believe that the conservative management was appropriate… I believe in view of her strength, her good quality renal function and her response to the initiatives that Dr Broadbent carried out, there were very positive and I believe that we could have got by without any surgical intervention, with confidence. Yes.' (T11-27, 28)"

[79] I have set out this finding at length because the burden of the applicant's argument was that the evidence did not support the Tribunal's finding that Mrs Pearce had an anastomotic leak. The evidence in support of the finding is rehearsed at length in the Tribunal's reasons. The applicant's attack on those reasons amounted to no more than a repetition of the evidence he gave before the Tribunal and an assertion that the Tribunal should have accepted the opinion of Dr Downes who performed the post-mortem. The applicant referred the court to some passages in cross-examination of Dr Wall who said that Mrs Pearce did not exhibit a number of symptoms of a patient with an anastomotic leak. He did not refer the court to that part of Dr Wall's evidence in which he said that, notwithstanding the absence of those symptoms, it was his firm opinion that such a leak existed. (AR 599 L22-L30) There was more than sufficient evidence to support the Tribunal's findings. No error has been shown.

[80] The applicant did not challenge, in his oral submissions, the Tribunal's findings with respect to instances 19 and 20. They were briefly dealt with in the applicant's written submissions filed 5 November 2010 which contain no reasoned criticism of the Tribunal's findings, and fail to refer to any evidence in support of the general propositions they advanced.

[81] The Tribunal's findings were supported by the evidence of Dr Wall who was retained by the Board to provide expert testimony. He explained in his report of 26 February 2008 why it was inappropriate to undertake the endoscopy of the patient with an anastomotic leak. The doctor said:

> "With respect to the role of upper GI endoscopy in the presence of an anastomotic or small bowel perforation and intra abdominal abscess formation, upper gastrointestinal tract endoscopy involves inflation of the gastrointestinal tract. The inflation is highly likely to cause further rupture of the bowel and possibly also rupture of the abscess into the peritoneal cavity proper. Only a small increase in the pressure of the gas within the lumen of the bowel will be responsible for sudden catastrophic events during the endoscopy. Possible catastrophic events are:
>
> 1. Rupture of toxic fluid into the peritoneal cavity leading to rapid onset of severe wide spread peritonitis and the onset of septic shock.
>
> 2. The introduced gas may dissect into the surrounding tissues and then in turn into a major vein which would lead to a sudden onset of circulatory instability due to massive air embolus.
>
> 3. Upper gastrointestinal tract endoscopy can precipitate death through introduction of the gas into the lumen of the bowel causing increased intra-abdominal pressure. This raised pressure can then displace clots in the pelvis which can lead to pulmonary embolus. There is a case for screening such seriously ill patients prior to carrying out such a procedure. This would allow the placement of a caval filter if major thrombosis was detected."

[82] In an earlier report of 12 February 2008 Dr Wall expressed his opinion:

> "The standards of care provided (by the applicant) were satisfactory with the exception of the care of … Mrs … Pearce. Mrs Pearce suffered an early post operative complication associated with failure to progress, severe infection and subsequently sudden death under anaesthesia. (The applicant) recommended and carried out an upper GI endoscopy to assess the patient's status. (The applicant) failed to diagnose an anastomotic leak. He failed to diagnose serious sepsis and he carried out an upper gastrointestinal endoscopy which was contra indicated. The patient's management contributed to her death. The failure to diagnose an anastomotic leak is responsible through causation (that is, the limiting of the patient's clinical pathways) for the patient's death. (The applicant's) care of Mrs Pearce was incompetent."

[83] It should be noted that the Tribunal rejected the complaint that the applicant failed to diagnose sepsis. It should also be noted that Mrs Pearce did not die from any of the catastrophes described by Dr Wall as reasons why an endoscopy should not have been performed. Her cause of death was cardiovascular failure which is a very rare but known risk associated with general anaesthesia. The point of the finding that the endoscopy contributed to Mrs Pearce's death is that the procedure should not have been undertaken in the particular circumstances. Had the endoscopy not been performed Mrs Pearce would not have been subjected to the general anaesthetic from which she died.

[84] The applicant has not made out any arguable case of error of fact in the Tribunal's findings. The application for leave to appeal should be refused with costs.

[85] **McMURDO J:** I agree with the orders proposed by Fraser JA in the respondent's application and with his Honour's reasons.

[86] I also agree that the application for leave to appeal should be dismissed. The proposed appeal would raise only questions of fact. In each case, the question would be one of medical or quasi-medical opinion. The Tribunal, constituted by Wall DCJ, had the advantage of the assistance of two assessors chosen from the professional panel of assessors relevant to Dr Broadbent's profession, as was required by s 31 of the *Health Practitioners (Professional Standards) Act* 1999 (Qld). Upon an appeal involving a reconsideration of those factual questions, this Court would not have the same assistance. That is not to say that leave to appeal should never be granted in this context. But that particular advantage held by the Tribunal means that the task of an appellant, or an applicant for leave to appeal, in challenging a factual finding about what was or was not a proper professional practice, will usually be formidable.

[87] Here the applicant's position is made yet more difficult by the fact that all but a few of the findings which he seeks to challenge were made by an acceptance of the evidence of a joint report of expert witnesses, some of whom had been nominated by the applicant. Of course the Tribunal was not obliged to accept their evidence. But as the reasons for judgment demonstrate, this and the other evidence was carefully scrutinised. There was no obvious flaw in this joint report. The applicant does not suggest, for example, that it was internally inconsistent or that it was partial to the Board's case. In many respects, it was unsupportive of that case. For the relatively few particulars which the Tribunal found were proved but which were not supported directly by that joint report, there was other evidence, not inconsistent with the joint report, which supported the findings.

[88] As Chesterman JA has explained, the applicant would seek to challenge the Tribunal's findings by arguing that his own opinions should be preferred to the apparently overwhelming evidence which the Tribunal accepted. The applicant has failed to demonstrate a substantial possibility that the Tribunal misused its advantages in doing so. I agree then with the orders proposed by Chesterman JA.