

# CONCLAVE and CONCURRENT EVIDENCE in MEDICAL NEGLIGENCE CLAIMS

In the Supreme Court case of *Kurt Halverson, by his tutor, Kenneth Halverson v Dobler*,<sup>1</sup> the court took an unprecedented step on the first day of hearing and ordered the parties to undertake joint expert conferences (conclaves) and to participate in concurrent evidence.

**T**he parties had not initiated this, though, nor did they make any interlocutory application for orders seeking joint expert conclaves and/or concurrent evidence.

The court's orders were explained to the parties as a means of promoting the efficient use of court time by synthesising, where possible, the disputed issues.

The plaintiff's legal team was apprehensive about how conclaves and concurrent evidence would impact on the plaintiff's case. We were concerned that the defendant's experts would attempt to over-complicate or blur the key issues in the plaintiff's case.

Both legal teams scamped to redefine tactics and to generate an agreement, where possible, on questions and materials that each expert's conclave would present.

This paper will briefly review the statutory requirements of conclave and concurrent evidence under the *Uniform Civil Procedural Rules 2005 (NSW)* (UCPR) and provide an overview of the writer's experience on the use of conclave and concurrent evidence in this medical negligence case.

## COMMENTS, AIMS AND OBJECTIVES

Exponents of concurrent evidence argue that it has many advantages over the traditional adversarial approach of obtaining and examining expert evidence. It allows the court to observe the interaction between experts and permits it to seek clarification instantly on issues raised in evidence.<sup>2</sup>

It has also been suggested that concurrent evidence enables the court, legal representatives and/or other experts to test and analyse expert evidence comprehensively, thus assisting the court in making the best decision.

The Honourable Chief Justice Peter McClellan, an advocate of conclave and concurrent evidence, asserts that the process is far more effective than the traditional approach:

'As far as a decision-maker is concerned, my experience is that because of the opportunity to observe the experts in conversation with each other about the matter, together with the ability to ask and answer each others' questions,

the capacity of the judge to decide which expert to accept is greatly enhanced. Rather than have a person's expertise translated or coloured by the skill of the advocate, and as we know the impact of the advocate is sometimes significant, you actually have the expert's own views expressed in his or her own words.<sup>3</sup>

Feedback from participating experts in the land and environment and administrative law jurisdictions has generally been positive, with most finding that the process allows them to communicate their opinions more effectively and to respond to the views of their colleagues.<sup>4</sup>

## UNIFORM CIVIL PROCEDURE RULES 2005 (NSW)

The idea of conclave and concurrent evidence appears to have arisen in the wake of judicial concern about the impartiality of some expert witnesses. Several studies found that judges had regularly encountered bias in expert evidence.<sup>5</sup>

Joint expert conferences ('conclaves') were thought to be a vehicle to overcome expert bias by placing like experts together to thrash out disputed issues and/or answer the prepared questions. However, using this mechanism was the exception rather than the norm.

Under Rule 31.24 of the UCPR, conclaves are likely to become the norm in medical negligence litigation. Although it is unclear when the conclave will be ordered, the greater emphasis on case management means that it will be ordered prior to and/or during the hearing.

The aims and objectives of conclaves have not changed: they are designed to synthesise disputed issues and to generate a 'report/agenda' for discussion at a hearing.<sup>6</sup>

In *Halverson*, the agenda generated following the general practitioner conclave appeared to indicate that the plaintiff's experts had moved on key issues.

In the post-conclave discussion, the concessions apparently made by our experts involved a misinterpretation of the questions when considered in isolation, and/or collectively.

They were adamant, however, that the defendant failed to exercise reasonable standards of care in not investigating,



properly or at all, the plaintiff's recurrent syncopal events and his recent 2/6 pansystolic murmur.

The court received the additional evidence in accordance with Rule 31.26(5) of the UCPR (which governs concurrent evidence and advises the practitioner that the court has the discretion to order concurrent evidence if it so desires).

**THE HALVERSON EXPERIENCE**

Four cardiologists participated in the court-ordered conclave. The defendant cardiologists were at the offices of the defendant's solicitor. The plaintiff's cardiologists attended by telephone.

The defendant prepared a thick volume of material that enclosed various electrocardiograms (ECGs), extracts from the plaintiff's lay witness statements and other miscellaneous material. The material was provided 24 hours prior to the conclave. Unfortunately, one of the plaintiff's cardiologists lived in the US, so was unable to receive that material prior to the conclave.

Two joint reports were prepared following the conclave. The plaintiff's report followed his central argument that he suffered from recurrent cardiogenic<sup>7</sup> syncopal events, and that had this been investigated at any time prior to his cardiac arrest, his long QT syndrome (LQTS)<sup>8</sup> would have been diagnosed and medically treated.

The defendant's report argued that all of the plaintiff's syncopal events were vasovagal,<sup>9</sup> and the isolated ECGs evidencing LQTS were attributable to post-cardiac arrest hypoxic brain damage, sympathetic storming, medications and/or electrolyte imbalances. Moreover, had an ECG been performed prior to the plaintiff's cardiac arrest it would, on the balance of probabilities, have been normal.

There were essentially two main causation issues in dispute:

1. Were the plaintiff's syncopal episodes cardiogenic?
2. If so, would an ECG, performed after the event, show an arrhythmia that was attributable to LQTS?

The court heard that LQTS may be caused by genetic

and/or environmental factors, such as drugs, electrolyte abnormalities, stressors that activate the sympathetic nervous system and/or brain injury; so the condition occurs only in the right environment.

The debate turned to whether the LQTS would have been detected had an ECG been performed at any time prior to the plaintiff's cardiac arrest. Unfortunately, the only evidence available to resolve this issue was several abnormal ECGs obtained after the cardiac arrest.

The cardiologists agreed that the ECGs taken on 12, 20 and 21 February 2001 revealed LQTS; however, its cause remained in dispute.

The plaintiff argued that the fact that LQTS had been detected shortly after the cardiac arrest reinforced his argument that he had congenital LQTS which had been exacerbated by other factors, namely the Epstein Barr virus (EBV).<sup>10</sup>

The defendant asserted that there was no pre-cardiac arrest environment stressor that may have caused or materially contributed to the LQTS. Furthermore, the plaintiff's hypothesis of the virus providing the environmental stressor to trigger the LQTS was not supported in the scientific or medical literature.

The plaintiff acknowledged the lack of scientific or medical literature specifically stating that viral illnesses may trigger LQTS events, but stated that in his case, in the absence of all other known environmental antagonists, the only remaining sympathetic nervous system stressor was the viral illnesses.

The exchange between the cardiologists on this causation point was robust and involved a considerable amount of court time. The following dialogue between opposing experts exemplifies the benefit of concurrent evidence in this case:

[Def. Cardiologist]: As we have both agreed previously, patients with long QT syndrome can have arrhythmias without any of these factors being present. You are postulating a new factor that hasn't been documented in the literature, previously: would you agree with that?

[Pl. Cardiologist]: No, I wouldn't agree because in the literature, sympathetic stressors are what is talked about >>

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and I believe if you looked at any of the databases you would see that sometimes there were viral illnesses, but to me it doesn't matter because we only have the viral illness in him. We don't have electrolyte abnormalities. We don't have any significant drug effects. We don't have myocardial ischaemia. We don't have brain injury prior to his arrest. We don't have significant bradycardia. We don't have hypothermia.

The only thing we have is the stress of his current viral illness and his history is such that all of his events occurred during viral illnesses.<sup>11</sup>

In his judgment, Chief Justice McClellan devoted a considerable amount of discussion to the evidence of the expert cardiologists. He acknowledged the dearth of scientific or medical literature supporting the plaintiff's proposition, but noted that absence of supportive literature does not preclude a finding, on the balance of probabilities, that the viral illness was the cause that triggered the LQTS. His Honour stated:

{The plaintiff's cardiologist} was of the view, which I accept, that the difference of opinion between the cardiologists was essentially due to the fact that as yet there is nothing in the scientific literature that says that viral illnesses specifically might lead to arrhythmias in patients with LQTS.<sup>12</sup>

## DISCUSSION

After the trial, the plaintiff's experts in the *Halverson* case stated that having similarly qualified experts (that is, general practitioners) providing evidence in concert, allowed the parties to express and rigorously challenge, defend and qualify their own and their colleagues' evidence, which ultimately exposed indefensible or minority opinion(s).

Conclave and concurrent evidence will be unavoidable in future medical negligence hearings.

The bench-led quasi-inquisitorial discussion is focused on gathering, clarifying, analysing and observing experts, providing the court with the information and material to make better-informed decisions.

Experts may intercede during or following an answer by aligned experts, possibly creating further uncertainty and ambiguity. However, in our experience, views outside the norm were usually met with a collective silence.

Concurrent evidence encourages judicial involvement, but it does not prevent, hinder or retard the cross- and/or re-examination of experts. However, any answer provided or issue raised is, theoretically, open for further discussion, if so directed, by the expert panel.

The key to the effective use of this time- and money-saving mechanism is to thoroughly prepare and brief your experts on the defendant's position, cross-reference and provide literature that supports your experts' opinions, and clearly define what you want to achieve from the conclaves.

## CONCLUSION

The *Halverson* case was the first medical negligence case in NSW in which the court, without notice, ordered conclaves and concurrent evidence.

Our initial apprehension of this process waned during the hearing when we were able to witness the exchange between opposing experts. Their discussion was rigorous and, at times, involved technical knowledge that would not have been provided but for that interaction.

Further, the stance adopted by some experts in their medico-legal reports and the conclave was not supported by the majority of the experts during the concurrent evidence process.

The opportunity for the court to observe collectively the interaction between the experts during their evidence gave it insight that would not have been readily available via the traditional approach.

This was a medically challenging case that involved multiple experts and traversed general practice, cardiology, neurology and emergency medicine. The use of conclave and concurrent evidence clarified several issues that would have been resolved only after extensive cross-examination of the defendant experts.

Contrary to our initial concerns, the conclave and concurrent evidence procedure was beneficial. Not only did it allow the experts to openly discuss and debate their views far more expansively than would have occurred otherwise, it also saved time and costs significantly – both the conclave and concurrent processes took a total of five days. Although the case was listed for 8 – 10 weeks (or 40 – 50 days), it ran for just 14½ days. ■

**Notes:** **1** [2006] NSWSC 1307 (judgment delivered on 1 December 2006). **2** Please note that the NSW Court of Appeal in *Botany Bay City Council v Rethmann Australia Environmental Services Pty Ltd* (unreported, NSWCA, 6 September 2004) has considered and approved the use of concurrent evidence and provided recommendations for its effective use. **3** Speech of the Honourable Justice Peter McClellan at the XIX Biennial Lawasia Conference on the Gold Coast reproduced in part in the Children's Court of NSW, *Children's Law News*, July 2005, p2. **4** See RG Pringle, 'An Audit of medico-legal conferencing', *Journal of the Royal Society of Medicine* Vol 96(6), 2003 pp454-7; speech of the Honourable Justice Garry Downes AM, President of the Administrative Appeals Tribunal, 'Concurrent Expert Evidence in the Administrative Appeals Tribunal: The NSW Experience' to the Australasian Conference of Planning and Environment Courts and Tribunals in Hobart – 27 February 2004, pp1–17. **5** I Freckleton et al, *Australian Judicial Perspectives on Expert Evidence: An Empirical Study*, Australian Institute of Judicial Administration, 1999 pp2-3; 23-39, 37-8; speech of the Honourable Justice H D Sperling, 'Expert Evidence: The problem of Bias and Other Things' Supreme Court of New South Wales Annual Conference – Terrigal, 3-4 September 1999, pp1-17. **6** Rule 31.26(4) UCPR. **7** Cardiogenic syncope: syncope of cardiac origin usually caused by arrhythmia. **8** LQTS: a complex range of conditions resulting in cardiac rhythm disturbance syndromes that can cause sudden death. **9** Vasovagal syncope resulting from a fall in blood pressure owing to a failure of peripheral resistance with concomitant reduced venous return, or due to slowing of the heart. This type of syncope is usually benign. **10** Epstein Barr virus: A member of the herpes virus family. It is one of the causes of infective mononucleosis. Also known as 'glandular fever'. **11** Transcript, pp716:18 – 37. **12** Para 131 p69, judgment of McClellan CJ.

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