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IN THE SUPREME COURT OF NEW ZEALAND
I TE KŌTI MANA NUI

SC 5/2020
[2020] NZSC Trans 22

BETWEEN **LESLIE NORMAN AUSTIN**
Appellant

AND **ROCHE PRODUCTS (NEW ZEALAND) LIMITED**
Respondent

AND **ACCIDENT COMPENSATION CORPORATION**
Intervener

Hearing:	10 September 2020
Coram:	Glazebrook J O'Regan J Ellen France J Williams J Arnold J
Appearances:	G J Thwaite and Y S Kim for the Appellant J A MacGillivray and S M Jass for the Respondent H B Rennie QC and J B Orphin-Dowell for the Intervener

CIVIL APPEAL

MR THWAITE:
May it please the Court, Gregory J Thwaite. I appear with Ms Y S Kim for the appellant.

GLAZEBROOK J:
Thank you Mr Thwaite, Ms Kim.

MR MacGILLIVRAY:
May it please the Court, MacGillivray with Mr Jass for the first respondent.

GLAZEBROOK J:
Thank you, Mr MacGillivray.

MR RENNIE QC:
May it please the Court, Hugh Rennie and with me Jonathan Orpin-Dowell for the Accident Compensation Corporation as Intervener.

GLAZEBROOK J:
Mr Rennie.

Before we start just a bit of housekeeping. Mr Rennie, we have your submissions. We're just wondering whether you would wish to be heard orally briefly. If so, we were proposing that that would be after the appellant and for no more than 10 minutes but we don't need to hear from you orally with your submissions but we are certainly happy to do so.

MR RENNIE QC:
Thank you your Honour, in the light of the submissions and you will appreciate our matters of intervention preceded those.

GLAZEBROOK J:

Yes.

MR RENNIE QC:

In that said could be said to be precautionary. We considered the position after the submissions came in and I confirm with my friends that the position that they would pursue is the position in their submissions. There are then really only two matters which I could see that our presence would serve. The first was simply to assist the Court if needed and that doesn't require me to say anything orally and the second was to draw attention as I have done in the written submissions to a provision that only really came to attention when the respondent's submissions were called. I do not wish to speak orally on either of those matters unless the Court wishes me to do so.

GLAZEBROOK J:

Thank you, we did consider whether we should ask if you wanted to be excused but we assumed that you possibly wanted to remain anyway just in case anything arose that the Corporation wished to be heard on.

MR RENNIE QC:

Yes.

GLAZEBROOK J:

But you certainly can be excused if you wish to be.

MR RENNIE QC:

Well I'm obliged to your Honour. I apprehend that what would happen would be that I would simply step behind the glass barrier and otherwise be present so if the Court is not troubled by this I will remain.

GLAZEBROOK J:

No, absolutely not but we thought that you might wish to remain anyway so thank you.

MR RENNIE QC:

Thank you, your Honour.

GLAZEBROOK J:

Now Mr Thwaite, can I just indicate that given there is no issue now with the test and we understand that you have confirmed that with the Corporation, we assume you will concentrate on why it is too early to know if this was an ordinary consequence and that really has been concentrated in the sense of what other material would be needed or would be available at a later stage that might change the view on that and then also you'd obviously need to deal with the two Accident Compensation Corporation points, the first one being section 33(1)(e) in terms of lack of informed consent and the other one being the effect of the review section in section 133(5) which are obviously new points that have been raised from the submissions that were filed on behalf of the Corporation and we're happy for you to deal with those in any order obviously so I'm not constraining you in terms of how you wish but just saying that those are the matters we're particularly interested in.

MR RENNIE QC:

Thank you, your Honour.

GLAZEBROOK J:

Thank you.

MR THWAITE:

May it please your Honours. I have filed my written submissions and what I propose to do is go to those as appropriate and then I have handed up an outline of some oral submissions which focus in particular on *Accident Compensation Corporation v Ng* [2020] NZCA 274 and *Roche Products (NZ) Ltd v Austin* [2019] NZCA 660, the Court of Appeal decision, and then I may make some comment on the submissions of the respondent.

As I understand your Honour's comments, I am to focus on whether there was any material that would have been required before the dismissal should have been affected.

GLAZEBROOK J:
I don't wish to divert you from your oral submissions please just present them how you would wish but in the course of those submissions if you could cover off those three points I mention and you can do it at the end of what you were going to say normally or whenever fits within the submissions so I'm not trying to direct how you give your submissions.

MR THWAITE:
Thank you, your Honour. If I could start with my written submissions. In my submission there are two ways of looking at the issue that the Court has set for argument. The first is was this procedurally appropriate and then the second is what is actually meant by treatment injury and that focuses on the question of ordinary consequence.

On the first and narrow point in my submission it is contract to establish principle for a case to be dismissed on a strike out where there is any prospect of evidence being available or there is a prospect of amending the pleading.

Now the statement of claim states a claim for relief to the extent that there is not a bar under the Accident Compensation Act 2001 and in my submission that is sufficient to plead that there are injuries that would not be covered by the Accident Compensation Act and thus the bar under section 317 would not apply and this is where a consideration of evidence would be required which obviously is not part of the strike out procedure and the key issue is DISH injuries which is a type of injury for which the ACC gave coverage but there was even in the ACC review a reference to DISH-like injuries. So it appears there are two type of injuries, at least DISH and DISH-like which are not necessarily DISH.

There was in the review of the Accident Compensation Corporation a discussion of different points of view between Dr Holtzhausen who was the medical practitioner for the appellant and experts retained by the Corporation, if I may refer to that, and the Accident Compensation Corporation's bundle of authorities and that is on page – it's right at the end in the final document. There's a reference to Dr Holtzhausen and it says: "On the other hand Dr Holtzhausen" –

ARNOLD J:
Sorry, which page are you talking from, page 9?

MR THWAITE:
It's page 9, your Honour, right at the end of that final document.

ARNOLD J:
So the document is the application for review by your client?

MR THWAITE:
Yes it is, your Honour and this is in the session dealing with causation and the reviewer says at the top of page 9: "On the other hand, Dr Holtzhausen stated that use of retinoids can potentially lead to disc nuclear dehydration and degeneration and long-term use of the retinoids can result in extensive soft tissue calcification including of the vertebral endplates and therefore potentially accelerate disc degeneration. In her opinion DISH-like lesions do occur in peripheral joints such as the joints of the carpus and that is most likely a secondary phenonium to the long-term Roaccutane use as it is quite an unusual area and the risk to see osteophytosis." And then the reviewer says: "On balance taking the weight of the medical evidence in total I find that Mr Austin has not established that his spondylosis and disc protrusions are caused by treatment. The majority of expert medical opinion in this case from different specialisations have agreed that causation has not been established." And then he continues, or he or she continues: "While I acknowledge Dr Holtzhausen's evidence it is not enough to discharge the

onus on Mr Austin to provide sufficient evidence showing that he meets the criteria within the Act to obtain cover."

So in my submission there is evidence that there are injuries or ailments as set out in the statement of claim suffered by the appellant which are not within the scope of the Accident Compensation regime.

WILLIAMS J:
That was due to causation, was it not?

MR THWAITE:
Yes, your Honour.

WILLIAMS J:
So how does that help you?

MR THWAITE:
Well it wouldn't be treatment then.

WILLIAMS J:
No, but the treatment is Roaccutane and that's what you're suing on.

MR THWAITE:
Yes it's damage caused –

WILLIAMS J:
So how would that help you with your civil claim anyway?

MR THWAITE:
Well if there isn't coverage given by the statue –

WILLIAMS J:
I get that point.

MR THWAITE:

Then it would be available and there is no bar.

WILLIAMS J:

Well except for the fact that the finding is that there is no causation but I suppose you would argue that that was wrong and you would want to argue that in the High Court?

MR THWAITE:

Exactly, your Honour, there is no estoppel arising from that determination, it is not a judicial determination and it wasn't given, it would appear, after trial it was given after correspondence so there was no opportunity for cross-examination.

ELLEN FRANCE J:

This is in the context of looking at the claim in relation to, I'm never sure how you say it, this spondylosis?

MR THWAITE:

I have to look at it, your Honour, to pronounce it properly. Spondylosis.

ELLEN FRANCE J:

Spondylosis. So I'm not quite sure how that helps you in terms of saying there's something else that's not DISH?

MR THWAITE:

There's a term DISH-like and that is a matter, for example, on page 4 of that review about two-thirds of the page down there is a reference to DISH-like lesions.

GLAZEBROOK J:

Perhaps it would help if you could just explain the difference between the two types of injuries because the issue probably is if they are mingled in together it becomes difficult to split them out in some way.

MR THWAITE:

Well they do occur in the same part of the body of course and they do appear similar but the evidence is the medical studies indicate that they are different injuries. I'd ask your Honours to bear in mind we haven't got even a statement of defence so we've made no progress in this case and matters of detailed evidence were not argued before the Court but in my submission the prospect of the evidence of Dr Holtzhausen being relevant or being persuasive there that is an injury which is not covered by the Accident Compensation Act.

GLAZEBROOK J:

But that split is not detailed in the statement of claim at the moment, is that the point about an amendment in the statement of claim could deal with that?

MR THWAITE:

Yes your Honour.

WILLIAMS J:

I guess the problem and logic with that is that if contrary to that finding you do establish causation then you are caught by the ACC Act by dint of proof of causation because that was the reason you didn't get cover in the first place.

MR THWAITE:

Well, we would want to see what the actual decision of the High Court was or how the argument in the evidence runs in the High Court. In my submission it's premature at this stage before we have precise evidence about the ailments.

WILLIAMS J:

Yes, but if you win you win because you've proved causation. Once you've proved causation that conclusion at page 9 is wrong and so you're covered by the Act.

MR THWAITE:

Well I would also have to prove that it was not an injury covered by that, that it was not a treatment injury.

WILLIAMS J:

Sure, but that raises the sorts of issues that we're talking about generally both with respect to DISH and this DISH-like thing, it's the same issue. I don't understand how this is helping you?

MR THWAITE:

I refer to Dr Holtzhausen's statement to show that there are ailments that are not DISH and the Court of Appeal ruled that DISH injuries since they have been covered by the ACC Act could not be sued upon but I'm referring to that to show that there are other ailments for which are not regarded as a treatment injury and therefore they could be the subject of the High Court action. So that's my primary argument on the evidence is that there is some evidence that indicates that there are ailments which would not be covered by the statute.

WILLIAMS J:

Yes, as I say the problem with that is that the reason for them not being covered is the finding is they weren't caused by Roaccutane at all.

MR THWAITE:

Well that's in the review, your Honour.

WILLIAMS J:

That's right, so to win you'd have to prove that wrong and once you've proved that wrong there's ACC cover on that basis.

MR THWAITE:

On the causation basis but the position of the appellant is that these injuries were, whether they were DISH or otherwise, were ordinary injuries resulting

from Roaccutane so they wouldn't be covered by the statue and therefore not covered by the bar.

GLAZEBROOK J:
All right, so just to be clear, you're not accepting by this argument that DISH injuries are ordinary so the point about what other information would be needed in respect of that submission still arises.

MR THWAITE:
Well on the ordinary point that is something I would come to when I look at the decisions in *Roche* in the Court of Appeal case and *Ng.* So there is some evidence that there are DISH-like injuries, spondylosis, for example, which might not be covered by the statute for whatever reason and that's a matter for discovery and for trial rather than for an elimination under the strike out procedure.

Now the statement of claim does claim for damages in respect to injuries which are not covered by the bar and in my submission that precludes a strike out at this stage until the statement of defence has been filed and until there has been some discovery as to the type of injuries that can result from Roaccutane. So it was an inappropriate procedure to strike out –

GLAZEBROOK J:
But that can only apply to the spondylosis, that argument, can't it, or do you say it applies more generally?

MR THWAITE:
Well a number of ailments have been listed in the statement of claim and the burden upon the respondent as defendant for the affirmative defence would be to show that each of those was covered by the statutory bar. So that's a factual matching, that's assuming that coverage was properly granted, it's a factual matter matching the ACC decision with the claims in the statement of claim and that's a matter that can be done at the strike out stage.

GLAZEBROOK J:

Well it could be done for some of them at the strike out stage and not others, couldn't it?

MR THWAITE:

Prospectively, yes your Honour, I accept that theoretically it could be done.

GLAZEBROOK J:

Well you need to explain why it hasn't been and can't be done in this case for –

MR THWAITE:

Well it hasn't –

GLAZEBROOK J:

Sorry?

MR THWAITE:

Sorry your Honour, I was waiting for your Honour to finish.

GLAZEBROOK J:

Well you need to explain why it hasn't been the case for all of those or some of them. Now one you say it hasn't been because there's not a statutory bar but what's the information in respect of the others?

MR THWAITE:

Well with respect I would say that since it's an affirmative defence the burden initiates with the respondent and that at this stage it's not possible to say on a strike out that none of those claims will succeed.

GLAZEBROOK J:

I understand that but you need to tell us why.

MR THWAITE:

If I may reach for the claim. Well the elements are identified in the blue bundle, the pleadings at page 101.0003, and there is a list there of 13 ailments and it's not intended to be a complete listing of the ailments and if the respondent contends, as it does, that all of those are covered by the ACC cover then it would need at a minimum to identify where in the ACC cover each of those is identified and that was not done at the Court of Appeal level and the pleading goes on to say that the claim is not barred by section 317 to the extent that such ailment was not a treatment injury. That was excess of pleading to even put that in because it really is a question of affirmative defence that at the strike out stage there is no call for evidence and there is no prospect at this stage of saying that all of those are covered by the accident compensation bar.

GLAZEBROOK J:

So which of those, if we can go through, do you say weren't actually granted cover?

ARNOLD J:

Well part of the problem is this list contains ailments or treatment, it's a compilation of two things. So another way of looking at it is your client was reimbursed some of his medical expenses. Did those medical expenses relate to expenses occurred for these treatments..

MR THWAITE:

Well that would be evidence that the respondent would wish to bring to indicate that there is an exact match between the ACC and those ailments or treatments. It might be that the respondent could do that on a summary judgment application but my submission the strike out procedure is not designed to resolve difficult issues, medical issues where there is evidence of a lack of agreement among experts. So it can't be said that this is a hopeless case or that there is no possible amendment or no possible evidence available.

GLAZEBROOK J:

I suppose the issue it comes down to is, and it is a relatively unusual case because presumably when applying for cover there was a need to say this does come within the ACC Act so presumably evidence was presented to say that it did come within that Act.

MR THWAITES:

It's a most unusual case, your Honour, and it can't be said that the appellant was slow to attempt to find the cause of his malady and he did consult a number of medical practitioners. When he found out, and this is in the evidence, when he found out he visited people and ensured that an application was filed. It was only subsequent to the application that litigation was commenced, so it is probably a unique case because it's a person who has filed the application and then later decided to commence litigation and yes there is a disequilibrium between the two claims that he has made, I accept that, but that's not a deliberate attempt to double dip or to engage in any type of deceit.

GLAZEBROOK J:

I can understand that but given that there was that earlier claim made and on the basis that it does come within the ACC Act we come back to the question what else would be provided by your client later that would make strike out inappropriate to say that it shouldn't have been part of that claim?

MR THWAITES:

Well that goes to the larger question of whether it was an ordinary consequence. Now with the knowledge of Roaccutane that has been gained and which was put before the Court, not with the commentary but just in terms of scientific literature, it now appears that going back to the ‘80s there was an awareness on the part of the Roche Group, the larger group not necessarily, it's yet to be proven whether that was the knowledge of the respondent that Roaccutane was dangerous so when that body of information became available there was then the question whether he had a cause of action against the Roche subsidiary New Zealand and then the linked consideration

whether in fact the ACC had been – the compensation had been properly granted. So, yes, it is accepted that there is a parallelism between those two claims and at some stage they will converge and one will be successful and one will not.

GLAZEBROOK J:
So you say the extra evidence takes it out of the ordinary consequences?

MR THWAITES:
Yes, your Honour.

GLAZEBROOK J:
All right, thank you.

MR THWAITES:
Now as I note on the bottom of page 2 of my submissions the Court of Appeal in what I will call the *Roche* or the *Austin* case in the Court of Appeal ruled that the claim for compensatory damages are struck out, the bottom of page 2, line 33 of my submissions but then in the *Ng* case the Court in its footnote said: "That the term was considered in *Roche Products* but the delineation of the boundaries of ordinary consequence was left to await the outcome of this appeal." And there is an inconsistency there, if one read the footnote only one would think that the claim for compensatory damages have not finally been determined because there was not a consideration of whether the ailments were the ordinary consequence of treatment and therefore would not be covered by the compensation scheme. So there is an incoherence between the two judgments in that respect.

GLAZEBROOK J:
Are you sure it wasn't just saying that the test was going to be decided in the later case? The boundaries of the case were going to be decided in the later case but the earlier case said whatever the boundaries this comes within it.

MR THWAITE:

Well that is an interpretation your Honour but I would say another interpretation is that the Court in *Ng* considered that it hadn't finally resolved in *Roche Products* this issue because it said the term was considered but it wasn't finally settled. Well if it wasn't finally settled then it was premature for the Court to strike out the claim.

GLAZEBROOK J:

Thank you.

MR THWAITE:

And the Court referred to the DISH injury that he suffered as a consequence of his treatment, I'm citing page 3 of my submissions but the statement of claim doesn't actually refer to DISH injuries but specifies the individual ailments. So the case had not yet reached the stage where it could be said that what was being pleaded was DISH injuries such that there was an automatic overlap between – a complete overlap between the accident compensation determination and the claim being made in the same claim by the appellant.

GLAZEBROOK J:

And you're content to say that if we wanted a shorthand we could say DISH injuries or DISH-like injuries, are you, or are there some of these injuries that aren't DISH-like?

MR THWAITE:

Well the third I would wish to have is spondylosis.

O'REGAN J:

So that's not DISH-like, spondylosis.

MR THWAITE:

I wish to keep it as a third category your Honour, although I'm being hemmed in to the binary DISH and DISH linked.

O'REGAN J:

So in the list of 13 in the statement claim how many of those are ailments which have been covered by ACC?

MR THWAITE:

That's not in the record, your Honour.

O'REGAN J:

But you accept some of them are?

MR THWAITE:

Some of them may very well be, your Honour, yes.

GLAZEBROOK J:

And where does spondylosis come within that list?

MR THWAITE:

I can't identify it in that list, your Honour.

GLAZEBROOK J:

Okay, all right. Please carry on.

MR THWAITE:

Unless your Honours have further question of me on that point I propose to move to the consideration of the concept of ordinary consequence.

WILLIAMS J:

Can I just check with you with some trepidation. That list of 13 ailments you argue are all consequences of Roaccutane treatment? Sorry, I used the wrong word, Roaccutane ingestion?

MR THWAITE:

Yes your Honour.

WILLIAMS J:

And ACC provided cover for injuries as a consequence of Roaccutane ingestion?

MR THWAITE:

Well that doesn't appear in the pleading your Honour, with respect, it's what the strike out –

WILLIAMS J:

No, I'm not talking about the pleading I'm just talking about cover, cover that was obtained?

MR THWAITE:

There was cover obtained as a result of the ingestion of Roaccutane, yes.

WILLIAMS J:

Why then would we ever think that any ailment that is the product of the ingestion of Roaccutane as you plead, it was not factually covered by the ACC decision?

MR THWAITE:

Because the statement of Dr Holtzhausen was not accepted that some injuries were not covered for causation reasons but if there is no causation there is no coverage.

WILLIAMS J:

Well if there is no causation there is no claim?

MR THWAITE:

Well the lack of causation has not been proven in a – I guess we're –

WILLIAMS J:

Okay, we're back to the point – the same point.

MR THWAITE:

We're going back to the same circle, your Honour.

WILLIAMS J:

All right, thank you. Anyway, there's nothing in there in that list that isn't Roaccutane related by definition?

MR THWAITE:

That's correct, your Honour.

Now moving to the important matter of or the substantive matter on the question of ordinary consequence and there are now two decisions, the Court of Appeal decision and this decision, and I think it's quickest if I go to my outline of oral submissions which I provided to the registrar, 3.2. The key terms used in both *Ng* and *Roche* relate to I suppose surprise. *Surprise* is the term used in *Ng* and the word *unexpected* in *Roche.* In my submission the question therefore is who is surprised and who finds this unexpected and there one must bear in mind that the Act is not that sympathetic to medical claims. In my submission the term *ordinary* is meant to limit coverage so it's a block and therefore the expectation or surprise cannot be that of the claimant, it must be that of an expert, and that was the reasoning of the fairly recent decision of the Court of Appeal in *Adlam v Accident Compensation Corporation* [2017] NZCA 457; [2018] 2 NZLR 102 and that is that there is the need for expert determination about treatment and therefore the question is who would be the expert. In my submission that's got to be a person who was familiar with the evidence about Roaccutane. So a person knowing about the record of Roaccutane back to the 1980s and as Dr Yoder who was engaged by Roche in the United States and he wrote two short letters about the potential dangers from Roaccutane and there is the article in the materials as to the rush to get Roaccutane onto the market.

The appellant's submission is that it would be the unexpectedness or surprise of such a person that would determine whether this was or was not an

ordinary consequence and if it is known to people who are in this area that it is an ordinary consequence then there can be no ACC coverage.

GLAZEBROOK J:
Ordinary consequence can't mean some possible but remote consequence, can it?

MR THWAITE:
It can be.

GLAZEBROOK J:
I'm just positing a situation where the issue is one in a hundred, say, or a thousand that a particular consequence can be found. In an individual case there will be an element of surprise if you happen to be the one in a thousand both from your medical practitioner's point of view and from your point of view I would have thought because you've got to say: "Well, 999 people don't get this consequence, it's bad luck and I'm surprised that you did."

Now obviously it's not a very useful term generally and that's why people have some difficulty with it but what do you say to that, do you say that is an ordinary consequence because it was known at the time because that would just about rule out anything other than something that has never happened before and therefore is a total surprise to everybody?

MR THWAITE:
Well, if it's a total surprise to the experts that I posit then, yes, that would not be ordinary.

GLAZEBROOK J:
But if it's known as a possible consequence in one in a thousand cases, you say that is an ordinary consequence?

MR THWAITE:

I would say it would be almost impossible to argue that one in a thousand would be an ordinary consequence.

GLAZEBROOK J:

Okay. So how likely does it – I mean, and obviously that was the issue in the recent case but…

MR THWAITE:

Well, the High Court went for the 50/50, which had the advantage of certainty, and the Court of Appeal said it can't be on a formula. Both the legislature and the judiciary moved back and forward between percentages, which have the advantages of comfort but don't really do justice, and so it may be that it's not, it's almost impossible to define "ordinary", it's like defining "normal", you have to define it in contra-distinction to something that's not ordinary or abnormal, and the appellant supports the conclusion of the Court of Appeal that it's very fact-specific. There is the famous comment of Justice Stewart of the US Supreme Court on pornography and he said: "I can't define it but I can recognise when I see it," and that may be about the best you can get with ordinary consequence. It's hard to define but when you see it you'll accept it.

GLAZEBROOK J:

Can I just try and see if I can get your argument, if I just say what I think the argument is and then you can tell me whether I'm right or not. So your argument here is that there is some evidence that was before the Court that this was a consequence of Roaccutane and that Roche knew about that, and it's not possible without full evidence to know whether that means it was an ordinary consequence or not, is that the argument in a nutshell on strike out?

MR THWAITE:

Yes, your Honour, subject to one reservation, and that is there was actually no need to put any evidence forward but the appellant chose…

GLAZEBROOK J:

Sorry?

MR THWAITE:

There was actually no need to put any evidence forward because a strike out by definition has no evidence.

GLAZEBROOK J:

Oh, no, sorry, I understand that. But there's at least, in terms of strike out there is something there that suggests that it could or could not be an ordinary consequence.

MR THWAITE:

Exactly, your Honour.

GLAZEBROOK J:

All right. Because, just saying, I think otherwise if you've got cover it would be difficult to say, well, ACC was wrong, and that's part of the issue on the 133(5) point, I think, that the ACC have brought up.

MR THWAITE:

Yes, I will address that, your Honour.

GLAZEBROOK J:

Yes. But anyway – no, you don't need to do it now though.

ARNOLD J:

Before you go on, I wondered if we could get any help about the meaning of ordinary consequence from the reference to a necessary part, so the treatment injury caused by treatment and not a necessary part of the treatment. Now, just stopping at that, *necessary* is a clear, firm standard, it's something that has to happen to you to get the treatment, and then it says "or ordinary consequence". Now the link between "necessary part" and "ordinary consequence" does suggest, doesn't it, that an ordinary consequence is

something that is regular, usual, something of that sort, some language like that, because that's how you sort of link an ordinary consequence to the notion of a necessary part. An ordinary consequence is something normal, regular, likely to happen, that kind of thing. Now if you take that perspective, the consequence that's been alleged here, just explain to me how your argument goes that that is a normal regular or usual consequence.

MR THWAITES:

Well firstly your Honour a necessary part and the ordinary consequence are together, I'm not sure conceptionally they should be together because necessary part is addressing another issue really, whether it's a consequence of that or intimately involved with that treatment, whereas ordinary consequence must be separate because if necessary part covered this situation you wouldn't need ordinary consequence so I would suggest that ordinary is a broader test rather than necessary and something can be ordinary without being a necessary part of it.

ARNOLD J:

Well the necessary part is talking about the surgeon making the first cut and all that sort of thing so that's an inherent part of let's say an operation or the treatment, ordinary consequences getting it a different idea, it is a consequence. I guess my point is don't you get some insight into the scope of what parliament is trying to talk about when it talks about consequence from the fact that it's used necessary part earlier on, that's the sort of thing that has been got at is something that is normal regular part of the particular treatment, whether it's a part of it or a consequence of it.

MR THWAITES:

Well I'd analyse ordinary consequence as having a different scope than necessary part and they are in the same clause but they don't overlap as your Honour suggests. The necessary part is part of the – one thing is a surgeon is making a cut in one part of a body to get to another and unfortunately cutting that first part causes bleeding or something, so it's just a necessary part of trying to operate in that part of the body but ordinary

consequence is what follows from that particular treatment rather than being an inherent part of that treatment.

WILLIAMS J:
You do get the sense that your argument really is that this consequence that your client suffered from even on ACC's analysis was an understood consequence, right?

MR THWAITES:
I think that's a good word to use, your Honour.

GLAZEBROOK J:
But not every understood consequence in terms of my example is an ordinary consequence.

MR THWAITES:
The one in a thousand may not be an ordinary consequence. It's an understood consequence.

WILLIAMS J:
The sense you get from the joining of the necessary cut with the understood consequence is that the consequence is something that is both understood and planned for, don't you think, something that comes within the procedure and what happens after it but the medical interveners understand as an ordinary consequence and plan for it because it is an ordinary consequence.

MR THWAITES:
I wouldn't attach the knowledge of the ordinary consequence to the people who are providing the treatment. They may not know it's an ordinary consequence and that would be the case here.

WILLIAMS J:
You'd expect them to though or there'd be an issue of competence.

MR THWAITES:

Well it could be an unknown unknown. If they had known there was a problem with Roaccutane and we're talking about a long time ago –

WILLIAMS J:

I understand that.

MR THWAITES:

– and there wasn't the Internet access.

WILLIAMS J:

But if it wasn't understood as an ordinary consequence back then that's probably problematic for you. The fact that something is an unknown unknown is probably fatal for you.

MR THWAITES:

No your Honour because there was no reason for them to know because there was an information asymmetry between the Roche Group and the people who were prescribing this medicine.

WILLIAMS J:

So you say we can discover an ordinary consequence after and still treat it as an ordinary consequence.

MR THWAITE:

Yes your Honour, because it was objectively an ordinary consequence although the person taking the treatment didn't know it. If the person taking the treatment had known it the person wouldn't have taken it and if the doctors had known they wouldn't have prescribed it or at least they would have given a warning and not prescribed it but because they didn't know it was prescribed but it shouldn't have been prescribed. If there had been a well-informed medical profession then and it would have been Roche to do that informing then I wouldn't be here today and neither would my client.

WILLIAMS J:

Wouldn't you think in the overall kind of structure of the no fault system in New Zealand that you're carving out a very large number of people who would want and need cover on a no fault basis if you're carving out anything that is problematic that isn't understood at the time but becomes understood later, asbestosis, for example, they'd all not have cover.

MR THWAITE:

Well the statutory intention was to limit cover for medical problems so it's not inconsistent with the purpose of the statute to apply the term *ordinary* in a rigorous way and the further point is that if coverage is given for pharmaceuticals that turn out to be defective then it would be a huge drain on the resources of the ACC particularly when those companies don't make a payment of a levy so the profits have been privatised and the problems are being socialised.

WILLIAMS J:

But how is that different from a negligent design or manufacture of a motor vehicle that results in accidents causing personal injury. I mean in that case there would be a claim under the Act, wouldn't there, for the personal injury and the fact that it came about because of the negligent defective design of a vehicle or whatever wouldn't matter, would it?

MR THWAITE:

That's true your Honour, but there isn't the concept of ordinary consequence in the compensation for vehicular injuries or for workplace injuries.

GLAZEBROOK J:

Surely you would have to look at it at the time whether it's an ordinary consequence and known to be an ordinary consequence at the time it was administered, wouldn't you?

MR THWAITE:

Yes, your Honour.

GLAZEBROOK J:

Otherwise it doesn't make any sense because you could have gone through whole review process had ACC paid for 30 years and then suddenly say: “Oh no, sorry, it was actually an ordinary consequence we've now found out,” I'm just thinking of some of those long-term effects that you can have of pharmaceuticals that are obviously not known even with the most rigorous testing processes.

MR THWAITE:

In my analysis they wouldn't be ordinary consequences because they weren't known at the time.

GLAZEBROOK J:

So you do accept that it has to be known at the time, it's not something that comes later.

MR THWAITE:

Yes your Honour.

GLAZEBROOK J:

All right.

MR THWAITE:

But the question is known by whom.

ARNOLD J:

So who do you say when you say: “Known by whom” what’s the answer?

MR THWAITE:

Somebody familiar with the literature at the time. So that's the two articles by Dr Yoder and some other articles that appeared prior to the first prescription.

ARNOLD J:

That is not necessarily the medical profession generally or specialists or?

MR THWAITE:

Well generally yes, your Honour, not by the practitioners who are administering this treatment. After all this treatment was given for acne and it's unlikely that somebody would think, I've got to think of the prospect of ossification before I prescribe for acne of the face.

ELLEN FRANCE J:

If you have a misdiagnosis and then treatment that follows from that how does your approach work in that situation?

MR THWAITE:

I hadn't turned my mind to that your Honour. May I check the statute? Well that would be a treatment under section 33 therefore it would be a treatment injury under section 32 and it would be covered by section 1(c) but there would be taken into account the clinical knowledge at the time of the treatment. So if this misdiagnosis was done in accordance with the clinical knowledge at the time then it would be an ordinary consequence. No, it wouldn't be an ordinary consequence.

ELLEN FRANCE J:

What I was thinking was if you had, for example, I don't know, a misdiagnosis for cancer and then you had some surgery and a claim for damages in relation to the surgery would that be an ordinary consequence or do you say you just don't get to that point?

MR THWAITE:

Well I think you do get to that point but that's a fact-special inquiry as to whether the diagnosis was in accordance with the clinical knowledge at the time.

WILLIAMS J:

You're not arguing about whether this is treatment, are you, anymore?

MR THWAITE:

No I lost that in argument in the Court of Appeal, your Honour.

WILLIAMS J:

Right, so maybe you're going to deal with this later but that takes this who should know question takes us to the point that ACC makes about 33(1)(e), doesn't it?

MR THWAITE:

I think maybe the respondent mentioned 33(1)(e) but that defines the treatment but then that's defined just for the purposes of section 32 so, yes, that misdiagnosis is treatment for the purposes of section 32.

WILLIAMS J:

I'm not talking about misdiagnosis. If the patient does not understand the consequences, and on your analysis the patient needn't, it's the experts who do, then obtaining prior informed consent or the failure to do so is treatment?

MR THWAITE:

Yes it is.

WILLIAMS J:

Well if informed consent includes, as it must, information about the consequences ordinary or otherwise your pleadings make it clear that Mr Austin was not informed it's his primary complaint.

MR THWAITE:

Yes.

WILLIAMS J:

Doesn't that make it treatment?

MR THWAITE:

Well it makes it treatment, yes.

WILLIAMS J:

Right. So given the focus on the informed consent of the patient do you think it's necessarily correct to say that their state of knowledge is irrelevant to the section 32/33 regime which I think is your argument, your thesis?

MR THWAITE:

In terms of defining ordinary consequence, yes it is.

WILLIAMS J:

So you distinguish between 33(3)(e) as relevant only to itself but not relevant to the overall question of who should know the consequences?

MR THWAITE:

Yes I do, your Honour.

GLAZEBROOK J:

But if because his doctors didn't know the consequence he didn't either then he won't have given informed consent. Well I think that's the point that's been made so even if he didn't have cover because it was an ordinary consequence he would have had cover because he wasn't informed of that and therefore didn't have the opportunity to decide whether he'd accept that as an ordinary consequence or not. That's as I understand the proposition. So just what do you say to that then? So it's an absolute separate ground of cover, let's assume it was an ordinary consequence. But if he wasn't informed of that and therefore could not give informed consent, doesn't he have a separate head of cover?

MR THWAITE:

No, I would say no, because "treatment" is defined for the purposes of determining whether a treatment injury has occurred, so it takes you back to section 32. So section 33 doesn't set up a distinct liability, it defines a term for section 32 and then one must go through the section 32 analysis.

WILLIAMS J:

Yes.

MR THWAITE:

Now the failure to obtain the consent, to make an informed decision, is a type of treatment injury but here the doctors presumably told him what they did know at the time.

GLAZEBROOK J:

Which because it left this out means it's not a fully informed consent even – so say a doctor negligently doesn't, here no negligence, you say, because they didn't know about it. But say negligently they forget to tell someone about what an ordinary consequence is then can there be consent if they're not told of an ordinary consequence?

MR THWAITE:

Again, we have to define, ordinary consequence known to whom? So if the doctors don't know about it they can't obtain his consent to it, but section 32 treats that as a treatment injury but then goes on to say that there's no cover if it's not a necessary part of the treatment.

WILLIAMS J:

Yes, I think the point, that I was driving at anyway, is that it clearly says the additional step of getting consent, which must be or ought to be informed, is part of the treatment, not just the administration of the drug but the prior obtaining of informed consent, right.

MR THWAITE:

Yes.

WILLIAMS J:

And the statute specifically talks about informed consent. It seems to me hard to divide that from the knowledge component in "ordinary consequence"

because if that were divisible in that way why would the statute refer to informed consent at all, why would it be relevant?

MR THWAITE:

Well, it says “the person’s consent, including any information to enable that person to make an informed decision”. They provided information, presumably orally, and he made the decision on the basis of the information then available, but it was a wrong informed decision.

WILLIAMS J:

Yes, but my question is really why is the statute wasting its time on the knowledge of the patient if the knowledge of the patient is irrelevant? They could have just said “obtain consent”, they didn’t need to refer to knowledge. Why are they specifically referring to it? It does seem to indicate that the person’s knowledge about consequence is relevant in the regime, because it says so.

MR THWAITE:

That's correct for that particular type of treatment or that *problem*, shall we say.

WILLIAMS J:

But you see it’s the same consequence that’s referred to in 32, must be. Because informed consent is always informed about what might happen to you if you take this drug.

MR THWAITE:

But once you take the section 33 into section 32 you’ve got to follow through the steps and, fairly or unfairly, if it was an ordinary consequence then you don’t have cover. They may not be a perfect fit between those two sections.

ARNOLD J:

Just, well, following up on that, section 32(1)(c) talks about “necessary part” and “ordinary consequence”, “taking into account all the circumstances of the

treatment, including, (ii) the clinical knowledge at the time of the treatment". Now that suggests, doesn't it, that an ordinary consequence is something that would be understood by clinicians of the time?

MR THWAITE:
Yes your Honour that's one factor to take into account. It's not definitive it's a factor to take into account and again it doesn't say whose clinical knowledge. Now if there's knowledge gained from experience outside and that is known or is ascertainable by Roche then –

ARNOLD J:
Well let me put it this way, if the doctors and others commonly providing this sort of treatment don't appreciate that it might have this effect on somebody such as your client but let's assume for the sake of argument that the manufacturer has done its own work which suggests such a reaction as a possibility, could you say it's an ordinary consequence bearing in mind that the clinical people and the hypothetical I put to you don't appreciate that this is a consequence.

MR THWAITE:
Well I would not accept with respect that the clinical knowledge is just that knowledge of the people doing the treatment, that that's a broader term to reflect one, people in this area know.

I would bring my conclusions on this point to an end by saying that the treatment injury is not part of the original scheme of the Act and has been fitted in awkwardly over the years but there is a perceptible interest in the legislature to have quite strong boundaries to prevent large claims for medical mistreatment, however that can be termed, and the ordinary consequence criteria is part of that arrangement to limit the exposure of the ACC and although it may be fair/unfair to some individual people that's a matter for the legislature to address and systemic problems such as opioids or other instances like that may need to be addressed by separate procedures that

enable class actions or funding or whatever but they would be simply outside the scope of the purse set up by the Accident Compensation Act.

O'REGAN J:
Can I just ask, are you positing the possibility that there could be sick cover under ACC for some of the reactions to Roaccutane and not for others and that so are you saying it's possible that you could have both if you had different consequences from taking Roaccutane?

MR THWAITE:
Yes, your Honour.

O'REGAN J:
So if you've got, for example, earnings related compensation from ACC because the injuries meant you couldn't work can you then claim more because you had other injuries that just confirmed that you couldn't work?

MR THWAITE:
Theoretically you could your Honour. Yes, it's a prospect.

And I would submit that the question: "What is an ordinary consequence?" is very fact-specific and couldn't be determined on a strike-out application.

If I could move – unless your Honours have further questions for me? I see that I've been talking for an hour and 10 minutes and the agreement was, I think, for an hour for the appellant. Is your Honour inviting me to continue?

GLAZEBROOK J:
Well, are you going to deal with section 133(5), the review provision?

MR THWAITE:
Yes, I am, your Honour.

Now this only very recently came up. It may be a further affirmative defence for the respondent, it's not something that I've really had the opportunity to consider in depth. But, as the ACC suggests, or as its counsel suggests, the procedure may presume that the ruling is adverse to a claimant and that the review and appeal procedure doesn't envisage a situation where an individual protests against his or her grant of coverage and therefore the section 133 bar might not apply where you have coverage and you're wanting to shed it. But its impact could be considered at the trial court level and not at this level, where there hasn't been a trial and there hasn't been a determination of the evidence.

ELLEN FRANCE J:
Wouldn't it mean, though, potentially that we don't have jurisdiction?

MR THWAITE:
The whole court system? Yes.

ELLEN FRANCE J:
So it's not just an affirmative defence that would be a bar to this Court or any court dealing with it?

MR THWAITE:
It would normally be raised by a defendant, your Honour, is what I meant by an "affirmative defence", and it hasn't been raised by the respondent, it's been raised by the ACC. But, yes, it is a critical point about jurisdiction. But it doesn't preclude the prospect of, as the ACC suggests, an extension of time to allow the claimant to object to his coverage. Presumably that would be a consent agreement with the ACC. It would probably be unlikely, but the ACC would hold him to an entitlement if he wished to surrender the entitlement, in which case the bar would be removed.

WILLIAMS J:

I'm not sure you can do any of this by consent. You're either covered or you're not, and ACC is bound to make the provision under the Act if you're covered and bound not to if you're not. You can't just say "Oh, okay then".

MR THWAITE:

Well, that's matter that would have to be, a process that would have to be begun, and it may be that the ACC accepts the argument about ordinary consequence and decides that it has made a mistake.

WILLIAMS J:

Yes, that is possible. I guess the issue for people wanting to test these things in the ordinary courts is the Limitation Act 2010, so you'd want to get your proceeding in as early as you could to avoid the effect of that. And it would probably be right to have some way of allowing an applicant to make an application – sorry, a claimant to make a claim – in the ordinary courts just to get their foot on the rug, as it were, before going to ACC, in areas where it's just not clear. But you can't have both.

MR THWAITE:

Well, with respect, eventually you can't have both. But it's hard for a citizen to have to decide without experience of litigation or medical matters as to whether to go the Court way or the ACC way. Now probably only one, unless there are different coverable and non-coverable consequences, probably there has to be a choice made eventually, but there is a two-year limitation period for commencing this action. So it was commenced and since then we haven't had a statement of defence, so we're now at the Supreme Court and this point has only been raised. If it had been raised earlier then a solution would have been found before we reached this point.

WILLIAMS J:

Well it all hinges on whether you've got a claim under the Act so it's a question of mixed fact and law. What's an ordinary consequence is at the core of it and

either one is right or the other but they can't both be, it's just a question of what process you need to go through to resolve that.

MR THWAITE:

Yes, your Honour. So the 133 bar will have to be addressed if the appellant is to continue in this litigation.

WILLIAMS J:

Well if you do have a claim under the Act and it is not an ordinary consequence then it is a bar.

MR THWAITE:

To the compensatory damages, yes.

WILLIAMS J:

Yes.

MR THWAITE:

Yes, it's a bar to the compensatory damages but it wouldn't be a bar to the exemplary damages.

WILLIAMS J:

Of course.

MR THWAITE:

So there is a prospect that the section 133 bar can be circumvented by a contrary decision of the accident compensation procedure. Through the accident compensation procedure if he can apply out of time if there is an extension of time.

WILLIAMS J:

It's a little strange to, as you say, you need evidence and so on to know whether it's an ordinary consequence, you've got to go through a trial to find out whether the Court has jurisdiction to have a trial. That doesn't make a lot of sense.

MR THWAITE:

No, section 133 the discovery of it has certainly led to some need to re –

WILLIAMS J:

Well it does suggest that the issue of whether there is claim under the Act is an issue that has to be dealt with. What does the Prime Minister say? "Go in early and go in hard," or whatever it is.

MR THWAITE:

"Go early, go hard."

WILLIAMS J:

Yes. It's got to be dealt with quickly and early.

GLAZEBROOK J:

And there are provisions in the ACC Act to require that to be done.

MR THWAITE:

Well obviously if it needs to be done we will have to do it.

GLAZEBROOK J:

But it has been done here, hasn't it, because there's already been a review.

MR THWAITE:

Yes there has so it may be necessary to take it to the District Court.

ELLEN FRANCE J:

Well for myself I still have difficulty in seeing how we can deal with it as a matter of jurisdiction on the current facts that's what I'm struggling with. I mean if there's a bar it's a bar to us at the moment.

MR THWAITE:

Well it's certainly an odd position to be in but it's a matter that could be remedied. It may require a stay of the proceeding until the bar is removed if it can be removed and that would not require the court system to take a final

position on whether the claim could be continued. My respectful suggestion is that that would be a matter for a trial court to determine whether it should stay the claim particularly given that this is a point that was not raised by the respondent, it was not raised by the ACC in the Court of Appeal, it was not raised by any of us and there being the focus on section 317 so the appellant has been caught by surprise.

ARNOLD J:

Well I don't think that matters. I think the fact is it's the law and as Justice France says, we've got to be satisfied that we've jurisdiction to do something and on the face of it we don't. I mean there is a claim. It has been allowed. There's been a review in relation to it. An element of it was unsuccessful. For myself I find it difficult to see how your client could relinquish the claim by agreement with ACC, I just don't understand that. So he would have to argue through the ACC process I guess if he can, well he can't do another review probably but he may be able to but that would be the mechanism and he would have to argue that "my claim should have been rejected".

MR THWAITE:

Yes.

ARNOLD J:

And if he was unsuccessful that would be the end of it.

MR THWAITE:

For the compensatory damages, yes.

WILLIAMS J:

And wouldn't that mean, if that analysis was correct, that the best you could get would be a stay of these proceedings while you wended your way through that?

MR THWAITE:

Yes, your Honour.

WILLIAMS J:

So if you got consent to a stay, is that what you're saying?

MR THWAITE:

No, I've indicated that it would be appropriate to have a stay. Now I didn't put it in my oral submissions but that would be the mechanism for allowing a time to determine whether the ACC coverage can be relinquished.

WILLIAMS J:

Yes.

MR THWAITE:

And it would be obviously made an either or accepting jurisdiction, but solely allowing the case to remain until that decision was made.

WILLIAMS J:

Well, the jurisdiction is about considering or granting remedies, so the end of the process. It's not a bar perhaps to filing.

O'REGAN J:

It's a bar to the Court considering it, that's right, isn't?

WILLIAMS J:

That's right, yes.

O'REGAN J:

But I suppose that's the merits maybe.

WILLIAMS J:

Yes, that mightn't, it wouldn't be, it's not a bar to these proceedings necessarily, it's a bar to the Court hearing them while that other process is going on in another place.

MR THWAITE:

Exactly, your Honour.

WILLIAMS J:

So why don't you go do that and we'll stay it?

MR THWAITE:

Well, that would be the best and reasonable outcome.

GLAZEBROOK J:

So is that all you have to say on that one?

MR THWAITE:

That's all that I have to say on that point, your Honour.

GLAZEBROOK J:

Are there any other points you have to address us on?

MR THWAITE:

I have one final thought on the ACC procedure, and it's an idea that arises from the ACC, is that possibly 133 would not apply to this unusual situation where you were trying to relinquish coverage. But the section envisages that the procedure has been successful after a protest against the declining of coverage. That's not an idea I've fully fleshed out but that may be a possible interpretation of section 133. But that's a matter that could be considered during a stay. It's certainly the most practicable way to circumvent the bar is to have a reversal of the grant of coverage to the appellant.

GLAZEBROOK J:

Thank you.

MR THWAITE:

That is all that I wish to add to my written submissions. I would suggest, your Honours, that I await the submissions of the respondent before responding to them.

GLAZEBROOK J:

Thank you.

MR THWAITE:

As the Court pleases.

GLAZEBROOK J:

Mr MacGillivray.

MR MacGILLIVRAY:

May it please the Court. I'd like to start by trying to assist the Court, before I get into my submissions proper, in relation to the distinction between DISH or DISH-like symptoms and spondylosis. The best document I think that gives the Court some guidance on this, just for the Court's reference, is the treatment injury report where ACC granted cover for one but not the other, which is the first volume of the exhibits at page 301.0082.

GLAZEBROOK J:

Sorry, I've looked and now lost it, the number. 82?

MR MacGILLIVRAY:

82, that's correct. 301.0082. This is the report behind the formal decision on cover, the initial one before the review, and under Part 3 of that, ACC's decision, third paragraph down, it notes that the diagnostic imaging feature for DISH is flowing osteophyte formation between vertebral bodies. So osteophyte are the ossification that we hear about, the bony growth on the spine. That's what DISH is. And as I've always understood it, the issue here about DISH and DISH-like is simply a descriptive one. Is it actually DISH or is it just something that looks like DISH and is symptomatically the same as DISH, so that's all that is, is a semantic difference, and then if you go down further to the last main paragraph on the page, the last full paragraph: "ACC have been advised in this case that DISH is a separate disorder to Spondylosis which is a degenerative arthritis affecting the facet joints and discs. The two conditions may co-exist, both cause pain and stiffness and

both may exist without symptomology," so one's a degeneration of discs, might cause a prolapsed disc or something like that, or compression, the other's the bony growths. That's as I've understood the distinction between the two.

GLAZEBROOK J:
Can you just tell us which one is which?

MR MacGILLIVRAY:
The spondylosis is the arthritic degenerative condition and DISH or DISH-like is the bony growths on the spine and it's absolutely correct that ACC have granted cover for one and not for the other on the sole basis that there was no proof of causation for the arthritis, the degenerative condition, not because of any other reason such as that it would be an ordinary consequence of taking Roaccutane. So it's purely a causation issue. So I hope that assists on that issue.

GLAZEBROOK J:
And so just to check it, I mean there's basically no causation because it's something that happens to people whether they take it or not and associate it with ageing, I'm assuming, is it mostly?

MR MacGILLIVRAY:
That's right and to the extent that my learned friend has found international literature on retinoids and what they can cause, it's causing bony growth that's causing that skeletal abnormality rather than anything to suggest that there's learning out there to suggest that it causes this sort of general degenerative arthritis or makes it worse, that's right. So really –

GLAZEBROOK J:
So are you saying the literature relates specifically to the ossification or growths?

MR MacGILLIVRAY:

Yes.

GLAZEBROOK J:

And not to the DISH-like if that's what we're talking about?

MR MacGILLIVRAY:

Spondylosis. Correct. And to jump forward a bit I do make the point that the Court in questions to my learned friend has anticipated that the only reason that the appellant doesn't have cover is because there was no causation. If he could establish causation he would have cover because there's no suggestion anywhere that taking an acne drug is likely to cause your spine to degenerate in this way. So you get with one hand, take away with the other. That doesn't get the appellant anywhere.

WILLIAMS J:

I guess that's true. His response up until that last sentence of yours would be yes, these are all – it's a pretty fact-rich summary and we'd like to argue that causation is wrong or something, the causation or conclusion is wrong or something, but doesn't help with the last sentence. That's the problem for him, isn't it?

MR MacGILLIVRAY:

No, it doesn't and in fact the noticeable thing about the only review or challenge to ACC's decision here has been an attempt to get more cover. It was a review to try and get cover for spondylosis which is self-defeating in relation to the claim against my client because if you establish that cover you have cover and you can't, under section 317, bring a proceeding for civil damages.

Your Honour, the clock in front of me says 11.29. I'm about to launch into ordinary consequences. Would that be a convenient time?

GLAZEBROOK J:
I think it would, thank you.

COURT ADJOURNS: 11.29 AM

COURT RESUMES: 11.49 AM

GLAZEBROOK J:
Thank you.

MR MacGILLIVRAY:
Thank you, your Honour. I want to turn now to what I have to say about ordinary consequence of treatment at a strike-out stage in this case. The Court of Appeal observed that ordinary consequence is an imprecise term which calls for judgment in each case and the respondent's submission is that the Court of Appeal was correct to conclude that whatever the precise parameters of that and how it might apply in other cases, this case clearly fell on the wrong side of the line for the appellant and I want to focus briefly on – because this is a strike-out, on what Mr Austin will have proved if he proves his case. If Mr Austin proves his pleaded case he will have established that taking Roaccutane as an adult to control acne for the most part between 1991 and 1996 caused ossification of his spine and other spinal issues that persisted for decades after he had ceased to take the medicine.

By 2015, almost two decades after end of his main usage of Roaccutane, osteophytes growing on his cervical spine had gotten to the point where they were blocking his throat and surgery was needed to remove these. He will have proved that he still lives with pain and discomfort and an increasing loss of movement that he has had to give up his livelihood as a result of that loss of movement and that he us unable to play golf or to drive a car for long periods. In other words, if Mr Austin proves his pleaded case he will prove that as a result of his treatment he suffered long-term severe adverse consequences that can only be said to be disproportionate to the purpose of

the treatment and the benefit to be derived of it in terms of type of consequence, severity of consequence, duration of consequence.

GLAZEBROOK J:
Can that necessarily be the case though because wouldn't you weigh up the benefits of the treatment against the likelihood of that risk arising just in any sort of normal decision that you might make?

MR MacGILLIVRAY:
Yes your Honour you would and that's why, for example, severe effects of chemotherapy, for example, might be proportionate the purpose of taking them which is a lifesaving treatment. Where I say the Court of Appeal was correct was to say that the effects in this case decades of severe spinal problems –

GLAZEBROOK J:
All I'm suggesting to you is that wouldn't you still weigh that up.

MR MacGILLIVRAY:
Yes.

GLAZEBROOK J:
Which might be in your favour actually, I guess, so that if the possible really bad side effects only happen in one and a thousand cases even if the benefits from treatment are not particularly high you might still take the risk because you've got a good – you've got a sort of a 990 out of 1000 possibility of not having that severe side effect.

MR MacGILLIVRAY:
That's correct, your Honour, and if you choose to take that slight risk and that's slight risk comes home and affects you in a severe way that you've suffered a treatment injury because you haven't suffered something that was usual, it's ordinary, it's expected. If you haven't consented to those side effects, you didn't know about them, you weren't told, you didn't take and –

GLAZEBROOK J:

Well you may have consented to them but decided that it was worth running the risk.

MR MacGILLIVRAY:

Absolutely, and that's correct your Honour. But where my learned friend ended up on this was to say that had medical practitioners and the appellant known that the likely outcome of this treatment was what happened to Mr Austin then he wouldn't have taken the drug and they wouldn't have prescribed it to him and I must admit that's absolutely right but what it shows is that he's obviously suffered something that is not an ordinary consequence.

WILLIAMS J:

You started off saying if he hadn't consented or if a theoretical person hadn't consented to side effects where were you going to take that sentence?

MR MacGILLIVRAY:

I was going to take that sentence to say that's the second leg of the double, your Honour, in the sense that if – and I will move onto that point – it's a necessary part of Mr Austin's claim against my client that he was never advised of the risk of serious skeletal abnormalities and, in terms of causation, that had he been advised of serious skeletal abnormalities he would not have taken the drug, he wouldn't have taken the risk. So those are both necessary for him to succeed against my client, that there were things about this drug that were concealed from him, it shouldn't have been on the market because they were so serious, and that had he known about that he would not have suffered the injuries that he's suffered. That's his case, and it needs to be his case to prove negligence and causation against my client. If he proves that, he will have proved that he has suffered a treatment injury because of lack of informed consent, lack of informed consent as a treatment. If that lack of informed consent causes your injury, it is a treatment injury.

GLAZEBROOK J:
And the answer that was given to that is it still had to be an ordinary, not an ordinary consequence?

MR MacGILLIVRAY:
Yes.

GLAZEBROOK J:
So what is –

MR MacGILLIVRAY:
But I think that collapses in relation to informed consent, I don't think it quite works, because I think it's trite. And I can put them in the bundle, but there are any number of excellent compensation decisions in the old appeal authority and now the District Court which say that if you didn't consent and you wouldn't have consented you've suffered a treatment injury. And, as your Honour observes, how that actually works with the definition or ordinary consequence, necessary part, is very tricky, but it's clear that that's the intention and always been understood to be the effect of the legislation. And I suppose the way that you would deal with that is by saying, well, no consequence that you didn't consent to is, for you an ordinary consequence.

GLAZEBROOK J:
It can be ordinary.

MR MacGILLIVRAY:
And that makes sense in the context of legislation that's designed to cover misfortune, things that are accidental and misfortunes rather than things that are expected, that for Mr Austin he couldn't complain if he said: "Look, I knew that was the likely outcome to me, I consented to that," that's ordinary for Mr Austin. If he said: "I have no idea and I would never have gone down the strike out, I understood I could be running those risks," it's not an ordinary consequence for Mr Austin is the way I would suggest that you would bridge that sort of slight disconnect in the way that the Act is drafted.

WILLIAMS J:
So there's a subjective element in that, obviously.

MR MacGILLIVRAY:
Yes. I think that where it comes to a lack of informed consent, absolutely, there has to be a subjective element to it.

WILLIAMS J:
Yes. So, well, you can read that into ordinary consequence if you like or you can say it's just an offshoot and that otherwise ordinary consequence is an objective test.

MR MacGILLIVRAY:
Yes.

WILLIAMS J:
Given the state of knowledge at the time and the underlying health of the patient and any other relevant factors.

MR MacGILLIVRAY:
That's correct, your Honour.

WILLIAMS J:
So you agree with that?

MR MacGILLIVRAY:
I do agree with that. And that leads neatly on to what I understood my learned friend's answer to what I've said so far, which is that the relevant knowledge, if we leave lacking informed consent to one side for a moment, that that relevant knowledge in terms of what was ordinary, usual, expected, is the knowledge of, the superior knowledge of the expert, the person who knows the most out there, who's done the literature reviews, that is aware of what Dr Yoder has uncovered in the United States. And the argument seems to be that if you can establish through that sort of expert analysis that, as it transpires, a

particular outcome was prevalent or likely, that that makes it ordinary. My submission is that that can't be right. The relevant knowledge to the extent that knowledge comes into it and in relation to expectations has to be, in my submission, the ordinary practitioner in New Zealand at the time describing this sort of medicine, administering whatever the type of treatment is, and the idea that something can become, that is unexpected to that practitioner administering the medicine into the patient receiving it, bearing in mind that the medical practitioner's knowledge makes its way to the patient by way of an informed consent process, that something that they don't expect, don't foresee, would never have intended can become ordinary simply because it later transpires that there was a defect or a problem or something that people hadn't previously realised cannot be right, and if that were the case it would drive a hole in cover for people suffering these sorts of misfortunes.

Your Honour, Justice Arnold, raised the example of a defective motor vehicle. To give you an example slightly closer here, in the *McGougan v DePuy International Limited* [2018] NZCA 91; [2018] 2 NZLR 916 case in the bundle the issue was defective hip implants that were found to be negligently or alleged to be negligently manufactured so that they gave off little shards that got into your tissue. Now if you were to take a hypothetical from that case and imagine that the manufacturer at some point knew about that and that it was getting out into the international literature that there might be this problem but that they were still being put into people in New Zealand because people didn't realise that they were defective, it couldn't possibly be the case, in my submission, that those claimants wouldn't have ACC cover because it later transpires that you're always going to have these problems with these hip implants. It was an inherent defect in them. They were always going to hurt you in this way. That wouldn't make it ordinary.

Another example that occurs is something like thalidomide which it transpired ordinarily causes birth defects. Again, somebody who took that drug having no idea about that, a medical practitioner who administered it having no idea about that, wouldn't later be said to, you know, it wouldn't later be said for a

claimant that, well, that's just the ordinary consequence because science has caught up and we now know that there was a problem with this drug.

GLAZEBROOK J:

So your submission is that even if Roche, and, of course, there's no suggestion in this case, knew that this was an ordinary consequence and hid it, that wouldn't make it an ordinary consequence if normal, ordinary practitioners not only didn't know but had no means of knowing it?

MR MacGILLIVRAY:

Absolutely not. In the context of an Accident Compensation scheme designed to cover people for adverse results that were for them and in the – out of the ordinary and severe and unexpected, that would, in my submission, make a nonsense of the scheme of the Act and, as said, would drive a hole into the Act. You would need to – you would have the situation where if, as I said, if it later transpired that something was defective and inherently wrong that there would be no cover and that, in my submission, can't be the test. The test –

O'REGAN J:

So are you saying it has to be the actual practitioner who administers a drug –

MR MacGILLIVRAY:

No.

O'REGAN J:

– or just an average practitioner?

MR MacGILLIVRAY:

An average practitioner with an ordinary clinical knowledge in New Zealand at the time. That's right.

O'REGAN J:

Wouldn't we need evidence on that?

MR MacGILLIVRAY:

You do have some evidence in the record on that, your Honour. I can take you to that. You've got a letter. This is at –

O'REGAN J:

Well, if it's contested though, isn't that a trial issue?

MR MacGILLIVRAY:

It would be if it's contested. I just didn't want to not alert you to the fact that there's something in the record on it.

O'REGAN J:

All right, well, by all means tell me where it is but I don't think you need to take us to it.

MR MacGILLIVRAY:

No, all right. You'll find at 301.0055 a letter from Dr David Downey who prescribed Roaccutane to Mr Austin and he says that his knowledge of side effects at the time encompassed various things. He says that his knowledge of side effects encompassed bone abnormalities in a paediatric population and goes on to say that: "I told Mr Austin things that were pertinent to the adult population." So that's what's in the records, your Honour. But…

GLAZEBROOK J:

Well, I'm not necessarily sure, and maybe that can be dealt with in reply, that Mr Thwaite suggests that it was something that was necessarily known to practitioners generally as against to your client, and you say that's not enough. Even if true that your client knew that, you say that's not enough if it wasn't a general knowledge among –

MR MacGILLIVRAY:

No, it's not. That's right.

GLAZEBROOK J:

Well, and, of course, it might be general knowledge but still not an ordinary consequence because of it being unexpected, whatever you use, out of the ordinary, severe, unexpected.

MR MacGILLIVRAY:

And where you'd come back to this the final piece in all of this that I think is fatal for the claim is that Mr Austin needs to, to succeed in his claim, come back to the proposition that I had no idea, I was not told and I would never have taken this medicine had I known and that –

GLAZEBROOK J:

And you say then ordinary or not ordinary is actually beside the point?

MR MacGILLIVRAY:

I do.

GLAZEBROOK J:

Sorry I probably jumped in but is that what the submission is?

MR MacGILLIVRAY:

It is exactly what the submission is, your Honour. Unless you have further questions on ordinary consequence I've dealt –

ELLEN FRANCE J:

Sorry, could I just ask one question?

MR MacGILLIVRAY:

Yes, your Honour.

ELLEN FRANCE J:

Putting that point to one side so that's the point about informed consent, the Court of Appeal at paragraph 34 said whatever the boundaries of that phrase ordinary consequences may be clearly intended to exclude unexpected and

significantly adverse medical outcomes disproportionate to the purpose of the treatment and the benefit expected to be derived from it.

MR MacGILLIVRAY:
Yes.

ELLEN FRANCE J:
And in the context of strike-out how does the Court know that's correct absent some consideration of the evidence?

MR MacGILLIVRAY:
On the pleadings, your Honour. The pleaded case is that Mr Austin took this drug solely to control facial acne as an adult and suffered adverse medical outcomes which I describe in the pleadings involving something that prevents him from working, from playing sport, has him decades after he's stopped obtaining any benefit from this treatment living in pain and discomfort. So I think in my submission this is one of those cases where you can get there on the pleading. It's not contested, it's not – I can't dispute it in this context and I'm not, I'm asking you to assume that what Mr Austin says is correct, that he stopped taking this in large part in 1996, took a little bit later but for short periods only and he's had the pleaded consequences and I say that's self-evidently an unexpected or a significantly adverse outcome and it is a case, and I know that the Court should be reluctant on strike-out where there is any doubt, but this is a case where I think the Court can say with fairness and confidence that the result is inevitable, if Mr Austin makes out his case that he's made out of treatment injury which is precisely why he got cover.

At paragraphs 27 and 28 of my written submission I deal briefly with the policy argument that somehow section 32 should be interpreted in a way that means that claims, that injuries whether caused by a defective pharmaceutical aren't covered. This seems to me to be the treatment argument where leave was declined in another guise and I would simply invite the Court, unless you have any questions about that, to refer to my written submissions on that. As the Court of Appeal noted, there is nothing in the scheme of the Act that suggests

that the bar was meant to cover some types of defendants and not other types of defendants. It's to cover any claim arising out of a treatment injury.

I then turn, your Honour, to the implications of the fact that Mr Austin has applied for and obtained cover under the Act and the ground has shifted on this partly because of the useful and insightful submission by ACC but partly I think also because of my learned friend's response to that. In the Court of Appeal as I understood the appellant's position it was not that the appellant wished to challenge or rescind or revoke his ACC cover but rather that he wanted to hang onto it.

GLAZEBROOK J:
Sorry, it wasn't, sorry?

MR MacGILLIVRAY:
That, as I understood his position in the Court of Appeal, it was that he, I think from recollection, was asked that he didn't mean to revoke or give back his ACC cover, rather he wanted the opportunity to run this proceeding, see what the outcome was and, if he was successful, recognised that, sort of like subrogation, that he's have to give some of that money back to ACC so that he didn't have a double recovery. There was no suggestion in the Court of Appeal that the appellant was surrendering or giving up in advance of a determination of this case his cover, and that influences the way that we've approached this, which is to say that if you've applied for cover, you've been to the Corporation, the Corporation's determined you've got cover, you'd received the legal entitlements that you're entitled to as a result of cover, and you keep those and you mean to keep those, that that must be regarded for the purpose of section 317 as cover under the Act, otherwise you undermine the statutory bar and permit what 317 expressly says you can't do, which is to bring proceedings if you have cover. I mean, this is, in my submission, an extraordinary case. I have not be able to find another case where somebody has applied for and has been successful in a grant of cover and has then come to court in the face of that saying: "Don't have cover." Plenty of cases where people don't make a claim, and that's why 317 says whether you've got

cover or not is not affected by whether you've decided not to lodge a claim or whether you've said that you surrender your rights under ACC, but I'm not aware of another case where somebody's doing what Mr Austin's doing. And we've made two submissions about that. One is that as a matter of law as things stand Mr Austin has cover and should be treated as having cover for the purposes of 317 and, secondly, if that's not correct as an absolute matter of law that the Court should nonetheless treat this proceeding as an abuse of process because Mr Austin would be pursuing rights that are inconsistent with legal rights that he has obtained through the ACC system consciously.

The grounds now –

GLAZEBROOK J:
But you wouldn't extend that to putting in proceedings just as a holding pattern? Because you may have to in terms of limitation.

MR MacGILLIVRAY:
No, I wouldn't.

GLAZEBROOK J:
So it's not the filing, it's just once you've succeeded on one then the other falls away, is that…

MR MacGILLIVRAY:
That's right. I wouldn't extend this submission to people who put in proceedings for Limitation Act purposes while they go through the ACC system, absolutely not. The ground has shifted somewhat, partly because ACC have helpfully pointed out that there's another relevant section that I hadn't turned my attention to that requires challenges to decisions made under the Act to be brought using the procedures under the Act or not at all and, secondly, because my learned friend has responded to that by saying: "Well, that's sort of what we intend to do and now want to do and might realise that we have to do." I submit that there is force to the points raised by counsel for the Corporation that section 133(5) does require challenges to decisions

made under the Act to be brought using procedures prescribed under the Act, and I submit there's force to the submission that where cover has been granted under the Act that grant of cover has to be set aside before, for the purpose of 317, you can say that there's a live dispute about cover or that cover might not exist and needs to be determined in proceedings. So –

O'REGAN J:
But that would be a stay point rather than a strike out point, wouldn't it?

MR MacGILLIVRAY:
Yes, I think it would, your Honour, and, as I said, the ground's shifted slightly because I've never understood the appellant to be saying that he intends to actually do anything to attack his ACC status. But your Honour's absolutely right, that if the appellant does intend now to take steps through the ACC process to attack his status, then the correct way to deal with that would be to, with one reservation, one serious reservation, which I'll come to would be to stay the proceeding, allow him to go through that process and then determine this application at the end of that process. My reservation is simply that we've found ourselves all the way here, it would be a shame for the issues on this application not to be determined by this Court even if it were on the basis that any – if it were a decision to strike out, that that wouldn't take effect until and unless the appellant were unsuccessful in challenging the decision of ACC and that in the meantime the proceeding would be stayed, because I'm simply concerned about what would happen if the ACC process were exhausted, there was no change, we then find ourselves in a situation where we had no determination of the issues that are before the Court.

GLAZEBROOK J:
Of course, one of the issues with that, I suppose, is, just for a claimant in that situation, is that you might find yourself with nothing, because you might find yourself with no cover and no claim. But I guess not in the circumstance you say and because in fact if there wasn't informed consent then there'd be cover on that basis, whether it's ordinary or not.

MR MacGILLIVRAY:

That's right, your Honour, and –

GLAZEBROOK J:

That's the submission.

MR MacGILLIVRAY:

It is the submission that – so if my – if the appellant has legal rights he can pursue through ACC to try and rescind cover and get a different decision from ACC then I think he's entitled to pursue those remedies and in those circumstances I would accept that it's appropriate that his rights be not prejudiced in a limitation sense. All I'm concerned about is that the issues in this proceeding do get determined so that if the outcome is no different we have a result, not finding ourselves in a position where we're needing to just relitigate the whole issue all over again.

O'REGAN J:

There's going to be a proceeding anyway though, isn't there, with the exemplary damages?

MR MacGILLIVRAY:

There's going to be a proceeding with the exemplary damages, that's absolutely right, and thought about whether from a limitation perspective to strike out now and then reinstate would be a fresh cause of action for limitation purposes. That would be the only danger, your Honour, of that being the solution to the issue. But you're absolutely right. There'll be an exemplary damages proceeding survive in the High Court. But I would've thought it would be possible to fashion an order that protected rights while delivering a result if nothing changes as a result of a challenge to the ACC process.

GLAZEBROOK J:

It is slightly difficult though, isn't it, in terms of ordinary consequence because there's a bit of a chicken and egg in that circumstance where –

MR MacGILLIVRAY:

There is. I –

GLAZEBROOK J:

So the best argument is probably the informed consent argument, I would have thought, in terms of getting a result now.

MR MacGILLIVRAY:

Yes, very much so, your Honour. I've always – I think that's the final problem because you have to to claim against my client prove that you didn't know, you weren't told, things were concealed and that had you known you wouldn't have taken the medicine.

So the reason that we proceeded by way of strike out is a sincere belief that this case is doomed to failure outside ACC.

GLAZEBROOK J:

And also perhaps in terms of ACC, in terms of your client you obviously had to prove that you wouldn't have taken it otherwise, but in terms of ACC if you're right it doesn't matter whether you would have taken it had you been given the choice, I would have thought. You still have an injury -

MR MacGILLIVRAY:

Yes.

GLAZEBROOK J:

– because the injury is not being asked for your consent even if you would have given it.

MR MacGILLIVRAY:

Yes, that's correct.

GLAZEBROOK J:

That's the submission?

MR MacGILLIVRAY:

Yes, it is. And my learned friend for the Corporation can deal with it but for my part it can't be right that the issue with ACC and it can now be dealt with on a consent basis, that's, from my understanding of the submission, not the way it will work. There will need to be a proper determination if that is to be challenged.

WILLIAMS J:

If you walk through that definition of treatment injury maybe they are reconcilable. So the prior informed consent. Does it use the word "prior"? It doesn't, does it? But that's the modern lingo. The informed consent definition of "treatment", which is a subset of "treatment injury"…

MR MacGILLIVRAY:

Yes.

WILLIAMS J:

The question then, because if the treatment is the failure to get consent we can say an injury by reason of failure to get consent.

MR MacGILLIVRAY:

Yes.

WILLIAMS J:

The question is, is it an ordinary consequence of that failure to get consent?

MR MacGILLIVRAY:

That's where it doesn't quite work linguistically.

WILLIAMS J:

Well, you might be able to – yes, but, well, perhaps…

MR MacGILLIVRAY:

Well, and I think you might have difficult situations, your Honour, for example where you could say: "Well, the issue that you didn't get my informed consent

on had nothing to do with the problem that occurred that was, that the two are different. Here's it's direct.

WILLIAMS J:
That's right. And can't you say, since this is the pleading, that Mr Austin says himself had he known he wouldn't have consented.

MR MacGILLIVRAY:
Yes.

WILLIAMS J:
So that the failure of consent must be, sorry, the injury, must be an ordinary consequence of the failure to get consent that he said he required.

MR MacGILLIVRAY:
Yes, that's correct, your Honour.

WILLIAMS J:
So they're not necessarily inconsistent.

MR MacGILLIVRAY:
No.

WILLIAMS J:
Well, sorry, not inconsistent but disconnected, if you like.

GLAZEBROOK J:
But if that's right it's always an ordinary consequence then consent would never be...

WILLIAMS J:
Is a prerequisite.

MR MacGILLIVRAY:
Well, it would never be…

GLAZEBROOK J:

Would never come there, because it's always going to be an ordinary consequence of giving consent.

ARNOLD J:

Yes.

MR MacGILLIVRAY:

It would never be a treatment injury. I'm sorry, I think I agreed when I shouldn't have. I think it's always going to be not an ordinary consequence because it's something that you didn't consent to and didn't expect it.

WILLIAMS J:

But the treatment, you see, the problem is that the definition of treatment is the consent, it includes consent itself or the obtaining of it.

MR MacGILLIVRAY:

Or the failure to obtain consent is also part of the definition.

GLAZEBROOK J:

So you'd say the failure to obtain consent means that anything that happens from that has to be a non-ordinary consequence because…

MR MacGILLIVRAY:

Yes, you shouldn't have –

GLAZEBROOK J:

Because nothing should have happened at all…

MR MacGILLIVRAY:

Nothing should have happened.

GLAZEBROOK J:

And so it has to be a non-ordinary consequence, is that…

MR MacGILLIVRAY:

That's right. The ordinary consequence of proper treatment would have been that you didn't take the drug, the practitioner didn't prescribe it to you. That has to be the way it works because this is, it's trite law that failure to obtain informed consent resulting in injury is considered to be a treatment injury under the Act.

GLAZEBROOK J:

So it has to be like that.

MR MacGILLIVRAY:

Yes.

GLAZEBROOK J:

Anything other than not having had that treatment is an extraordinary consequence because the only ordinary consequence of that is nothing happens to you at all.

MR MacGILLIVRAY:

Yes, that's right. It's the example that can turn things that ordinarily would be a treatment injury into a treatment injury.

GLAZEBROOK J:

Yes.

MR MacGILLIVRAY:

It's the situation where if someone doesn't tell you what the effects of chemotherapy are and you can satisfy the Corporation that had you known you wouldn't have undergone it…

GLAZEBROOK J:

Well, I'm not even sure you need to go that far really, because if you didn't consent to it it may just be that it's not an ordinary consequence.

MR MacGILLIVRAY:

Yes, indeed.

GLAZEBROOK J:

But, I mean, we don't need to decide that because that's not the case here.

MR MacGILLIVRAY:

No.

GLAZEBROOK J:

But it may be that case. Because the only ordinary consequence is not getting it. So if you did get it, whether you would have consented or not, which is always very difficult…

MR MacGILLIVRAY:

It is.

GLAZEBROOK J:

Because you'll always say: "I wouldn't have consented," because it turned out to have this adverse effect. If it had a good effect you'd say…

MR MacGILLIVRAY:

Absolutely. And that's exactly the argument that, you know, if this were to be run as a (inaudible 12:24:18) civil claim, exactly the type of argument you'd be having, given what somebody might have told you about the likelihood of this and how you were suffering, what decision would you have made?

Your Honour, unless the Court had any further question for me those are my oral submissions.

GLAZEBROOK J:

Thank you very much.

Mr Rennie, I probably should ask whether anything that's arisen means the ACC thinks it might have to say something?

MR RENNIE QC:
I might just make just a couple of statements. You've been dealing with the consent question. The departure point for a claim of course is having sustained personal injury and if a consent was not obtained then of course that is a medical error in itself and a claimant to the Corporation who has had an injury and can show that the process by which that injury was obtained would be travelling down a route possibly less torturous than the Court may have thought in terms of arriving at an entitlement to cover.

The treatment injury section really deals with those cases where the medical process was correct but the outcome was within the categories which were not anticipated and the previous legislation applied a rarity test which was on a percentage basis and the Court will be aware that I was counsel in *Ng* and the Court of Appeal, perhaps unsurprisingly, Justice Goddard in particular focused on the issue that percentages were not helpful because you actually had to reconcile your specific case to the percentages which often are on very low numbers or out of demographics or geographical areas of ethnic or other considerations which mean that you don't really have a reference base as such and that comes back to where the parliament took the matter having discovered that a percentage figure was at times not only not helpful but could even be cruel if the statistics at that moment in time happened to push you slightly outside the 1% barrier, it came back to a fact-specific case.

And the only other thing that I would add is there was reference, and I don't mean to be offensive about this, but there was reference to the question of a corporation doing a deal. The Corporation, with respect, does not do deals. The Corporation is a statutory entity and we have been conscious in this that we have both the duty to inform the Court as to the processes which were open to both parties which is where the reference to 133 and so forth came out when we looked at what the respondent had to say and also to remain sufficient independent in a perspective on this case so that if Mr Austin were

to apply to the Corporation literally years out of time for an indulgence as to even having that application heard and then to consider where that application might go that that's a matter that the Corporation has quite intentionally given no thought to because it would have a decision making process to address if that did arise. Those were the points that came to mind in listening to the argument.

GLAZEBROOK J:
Thank you, and we totally understood that last point.

Can I just come back to your first point in terms of no consent obtained?

MR RENNIE QC:
Yes.

GLAZEBROOK J:
I'm not sure I quite understood the issue there.

MR RENNIE QC:
Well the necessary part of the medical process of the administration of a treatment is the consent.

GLAZEBROOK J:
So you'd say it comes under the necessary part aspect, does it?

MR RENNIE QC:
Well yes because if there is no consent then that is medical error and what we're dealing with here is not a case of, well I mean I appreciate Mr Austin may now say that he did not give consent. Well that would found a claim to cover independently of the nature of the injury that he had suffered because that's a process failure. Legislation does not provide for a situation where you speculate as to what the consent might have been if the consent was not obtained.

GLAZEBROOK J:

So that was my point. I was saying that there is not a necessary – so the corporation would accept it's not necessary for somebody to prove that they wouldn't have consented had they been given that information, it's a treatment injury – well assuming there's an injury.

MR RENNIE QC:

If they can show that the process which led to their treatment lacked a stage in it which was medical error, namely, that is proceeded without obtaining the consent then that grounds and application for cover, assuming you've got an injury, that grounds and application for cover on that failure of medical error.

ELLEN FRANCE J:

Does that come solely from the "not a necessary part"?

MR RENNIE QC:

Essentially, yes.

WILLIAMS J:

So that means that "ordinary consequence" need not have detained the Court of Appeal at all, or Justice Churchman for that matter and *Ng*.

MR RENNIE QC:

Well, possibly so, but the Corporation responds to litigation situations that arise so…

WILLIAMS J:

Quite.

GLAZEBROOK J:

All right, so perhaps if I can just give an example, just so that I'm absolutely clear. You go in for an operation on one thing and instead, well, or instead as well but not from – not by mistake but because of good clinical reasons your toe is amputated. If you didn't give informed consent about that would that be

therefore an injury, the loss of your toe would be an injury that would be covered merely from the fact that you didn't give a consent?

MR RENNIE QC:

Well, indeed, because it's a personal injury by accident –

GLAZEBROOK J:

Right, yes, so –

MR RENNIE QC:

– the accident being the defect.

GLAZEBROOK J:

That's what I understood your submission.

MR RENNIE QC:

Yes.

GLAZEBROOK J:

I just thought I'd give an example that we could just be absolutely clear.

MR RENNIE QC:

Yes. I felt it important to emphasise that this is – where the Court is focused in this case is what you might describe as the residual area where medical treatments proceed with an objective which is not achieved and in some but not all circumstances Parliament has provided for cover to be available, and Mr Austin obtained that, applied for that cover, obtained that cover, that cover is current. There's no suggestion he hasn't got continuing cover but he clearly feels that Parliament should also have allowed him something more, or different.

WILLIAMS J:

One – I must say I'm rather attracted to that approach because it takes away a really difficult area, but one problem perhaps is that 33(1)(e) refers not just to the obtaining but to the failing to obtain and says that's treatment too.

MR RENNIE QC:

Yes.

WILLIAMS J:

It says failing to obtain is also treatment.

MR RENNIE QC:

Yes, well, failing to obtain is within the definition of the circumstances which lead to the existence of cover. Treatment is used in that section in a wider fashion than would normally be taken to be the meaning.

WILLIAMS J:

It's not, yes, it's not a beautiful piece of drafting but if –

MR RENNIE QC:

It's not a –

GLAZEBROOK J:

Well, we are talking about the Accident Compensation legislation so…

WILLIAMS J:

It would be better if they hadn't referred to the failure so that therefore treatment would – a necessary part of treatment would be the obtaining of consent, clear as a bell, and the failure to provide a necessary or a consequence that's not a necessary part of treatment would be covered, sorry, something that's not a necessary part of the treatment would be covered.

MR RENNIE QC:

Would be covered. Well, it's not I think the Court would accept my task to defendant the drafting of the legislation. The Court may feel the prisoner of it but today the Corporation is the prisoner of it 365 days a year and every fourth year 366 and I can certainly indicate that the exact interpretation and application of this area has been particularly difficult over the period as I think

is evidenced by Parliament's successive attempts to find a way of allowing for the recognition of adverse outcomes of a nature that is consistent with the concept of compensation for personal injury, and if I can just make this point that medical treatment, of course, includes, as it does here, medication. It's quite often a trap to fall into thinking about this area in terms of surgeons and emergency surgery and all that kind of thing. It would not under the Medicines Act 1981 be possible to register a medication where the probability was that there would be an adverse outcome and so in the medication areas you're dealing with quite low orders of occurrence and that was indeed the area where Parliament moved from a rigid barrier to a fact-specific case as was held in *Ng* which had been the position under *Childs v Hillock* (citation 12:35:10) before the 1992 tightening, shall we say, of the ACC legislation.

If the Court pleases. Thank you for allowing me to say that.

GLAZEBROOK J:
Thank you very much. Mr Thwaite.

MR THWAITE:
I have five brief points your Honours. My friend referred to the disproportionate test when analysing the taking of Roaccutane in respect to acne but the disproportion is part of the test set out in *Ng* in that it is unexpected and disproportionate, so there are two elements to that test and, yes, one is disproportionate but that in itself is not the sole criterion for ordinary consequence, it was also the unexpected requirement.

The second is the concept of nondisclosure. It's not the only part of the plaintiff's case. The plaintiff does plead in the statement of claim that there was negligence. One of the particulars of negligence was failing to take the product off the market and that's in the statement of claim in pages 101.0005, 6 and 7, so this case is not solely about failing to advise but failing to take the product off the market.

Thirdly, the submission that I have made that the surprise or un-anticipation is to be measured on the basis of people who are familiar. It's an era when this occurred that there was no Internet access. One would imagine now with the greater speed of exchange of knowledge defects in drugs like this will become known to practitioners in Auckland. And Dr Downey at least knew of problems with children but it is disputed whether there was any knowledge of problems with adults or whether there was any warning given but the problem in this case between a lack of knowledge in Auckland and the knowledge overseas will probably occur less or not at all with the speed of moving information around the planet.

Fourthly was my learned friend's submission that there would be a hole driven through the legislation if a greater range of outcomes were regarded as ordinary consequences. In my submission the legislation has that pre-existing hole because of a determination to put a boundary somewhere in compensating for medical treatment.

And fifthly, my friend did refer to the status of the case in the Court of Appeal. It's true the focus has shifted but the focus in the Court of Appeal was on the suggestion of double dipping and that is when there was the proposal as I believe is recorded in my learned friend's submissions of returning money to the ACC. With the disclosure of the bar under section 135 of course those considerations are no longer applicable.

So those are the only matters that I have in reply, your Honours, unless your Honour has further inquiry of me.

GLAZEBROOK J:
Thank you very much.

MR THWAITE:
Thank you, your Honours.

GLAZEBROOK J:

The Court will take time to consider and give its judgment in due course and thank you very much to all counsel for their submissions and we will now retire.

COURT ADJOURNS: 12.39 PM