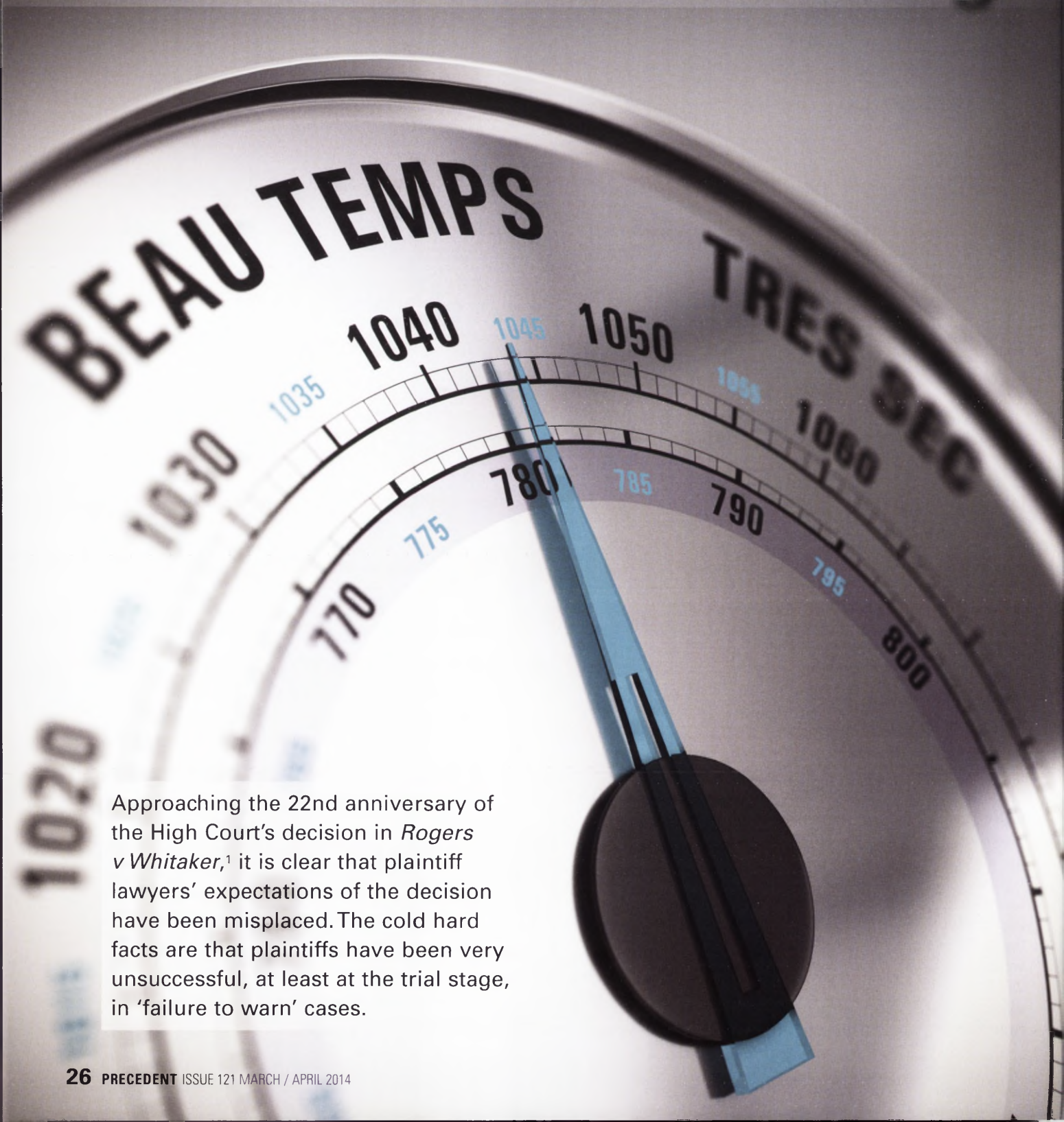
By Julian Johnson

'Failure to warn' cases: A warning!



Approaching the 22nd anniversary of the High Court's decision in *Rogers v Whitaker*,[1] it is clear that plaintiff lawyers' expectations of the decision have been misplaced. The cold hard facts are that plaintiffs have been very unsuccessful, at least at the trial stage, in 'failure to warn' cases.

The decision was greeted with considerable enthusiasm in some quarters, if not euphoria. At last the 'bad old days' of cronyism in cases concerning adverse outcomes from healthcare were over. No longer would it be a sufficient defence for a defendant medical practitioner to line up a bunch of chums to all say they did (or would do) precisely what the defendant had done. *Bolam*[2] was dead and a new era of self-determination (the 'paramount consideration') and accountability would follow. Standards to be expected of medical and other health professionals would be determined by what other, informed judges (literally) considered reasonable; not by common practice, which could be based on expediency.

Most tellingly, in the area of health professional and patient communication, the expectations to be set would be fundamentally underpinned by the primacy of patient autonomy. No longer was it 'doctor knows best'. No more medical paternalism. Health professionals would now be obliged to inform their patients of all of a proposed treatment's risks that were likely to be significant to the patient in **their** decision whether or not to proceed with the treatment.[3]

Health consumers were buoyed by the High Court decision. They expected new improved levels of openness, disclosure and discussion with their health professionals. Plaintiff lawyers in the area expected a growth in cases following the new higher standards .

But an analysis of the facts reveals that the expectations of plaintiff lawyers, at least, have not been met.

A Barnet search[4] of the past 10 years of Australian superior court decisions in 'failure to warn' cases shows that the plaintiff succeeded in only three of 15 cases (20%) (see the table below).

Of the 12 unsuccessful cases, breach of duty was made out in five (Di Carlo, Kerr (on appeal), King, Waller, Wallace). Causation was not made out in any of the unsuccessful cases.[5]

What can the plaintiff lawyer learn from these cases?

BREACH OF DUTY[6]

It might seem obvious, but make sure you understand the medicine: in terms of the treatment provided, how the complication occurred and its incidence.

The internet is your best friend for this! Apart from Medline and a sea of consumer-friendly medical information sources (of varying reliability), YouTube (provided you have a sufficiently strong stomach), should enable you to watch an example of the very operation your client underwent. This can be invaluable.

Also, if possible speak to your expert (your 'next' best friend), rather than simply seeking a formal written report. I have found informed discussion with an expert a much better guide to the strength or weakness of a given case, than a crafted report alone.

Key issues to focus on in your initial medical investigations are:

- What was the scale of risk for the patient – both recognised in the general literature, and specifically, if/when the information is available (generally later, in proceedings)?[7]
- What were the pros and cons of the treatment undertaken and of any reasonable alternatives?

The wider the range of treatment modalities reasonably available to treat your client's health problem, the greater is the onus on the health professional to provide an explanation of risks and so the stronger your potential 'failure to warn' case. This is because the range of risks likely to be of significance to the patient when choosing treatment (or no treatment) increase, the more balanced this choice becomes.

CAUSATION: A WARNING (OR TWO)

If the above inquiries lead you to feel optimistic that a warning ought to have been given about the risk or complication that has occurred and was not,[8] 'hold on!'

In my view it is critically important to appreciate that there are many cases in which breach can be made out for a failure to warn, but a claim overall cannot be maintained. This is because establishing breach has a lower threshold than establishing causation. This is a critical point to understand.

As mentioned earlier, the health practitioner's duty is to warn of all risks likely to be of significance to their patient deciding whether or not to undergo treatment. Breaching this disclosure obligation occurs if the risk is likely to have had some influence on the patient's decision. This is a low threshold to meet.[9] It need not, for example, be shown that it ought to have been foreseen as potentially decisive to the patient's choice.

But the seriousness of the risk about which the warning ought to have been given must be of **greater** probative importance to make out causation than to establish breach.[10] To establish causation the patient must prove that if appropriately warned, they would not have proceeded with the relevant treatment, at least not at the time they did. In other words, in this context (in contrast to establishing breach), the risk that was not disclosed must be proven as likely to be decisive.[11]

As a matter of common sense, situations in which a health professional fails to disclose a risk associated with a proposed treatment that in fact would have been decisive to their patient's decision whether to undergo the treatment, will occur less frequently than a breach of duty. This is primarily because most doctors will warn patients of the central risks likely to be decisive to the decision whether to proceed.[12] Furthermore, most health professionals will only recommend treatment they consider likely to be beneficial for their patient. If the knowledge possessed by the surgeon or other health professional leads them to conclude it is in the patient's best interests to proceed, it will be an exceptional case in which the patient would reach a contrary conclusion (and even more rarely would they be able to prove this).[13]

This presents an 'odd' situation. A patient has not been warned of a risk of complication which has eventuated and >>

therefore caused them injury (possibly of a serious nature), yet often they will have no entitlement to compensation for such injury because they cannot prove that prior warning would have changed their decision. This is frequently and understandably a cause of outrage for the disappointed client. Advice that a disciplinary complaint may be lodged for the duty breach is often small comfort.

The most important 'advantage' that plaintiffs have in relation to 'failure to warn' cases and causation, is that it is sufficient to make out causation if it can be established that if appropriately warned, the patient would have delayed/deferred the treatment.[14] It is not necessary to show that the plaintiff would never have decided to have the treatment.

This opens the door to argue that being informed of a risk that eventuated may have led the patient to pause, defer treatment for a period, perhaps seek a second opinion or, in more risky circumstances, seek out the 'best' surgeon they could. This may be a far more convincing alternative to arguing that treatment for significant symptoms would have been refused point blank.

In my view, it is unfair that the onus of proof, once a failure to warn is made out, should rest on the plaintiff in relation to causation.[15] If the health professional is shown to have breached their duty of disclosure, why should it not be up to them to establish that this should be ignored on the grounds that it would not have altered the patient's decision?

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Adding some insult to this injury are the evidentiary provisions in some jurisdictions, including WA, which preclude a plaintiff from being able to state what they must prove: that they would not have proceeded with the treatment if they had been properly warned.[16] That is, they cannot say directly what they would have done if warned. The argument must be based on circumstantial evidence etc.

In my view it is critically important to adopt a common sense and 'real world' knowledge of the relevant medicine when formulating, articulating, and most importantly, pleading the risk which is said to have arisen and of which it is alleged warning ought to have been provided. Following the High Court's decision in *Wallace,*[17] from the plaintiff's perspective the broader such risk is defined the better.

My own view is that the risk should be defined with the breadth and in the terms that a competent health professional ought to have articulated their warning to the patient. This is preferable to the more common formulation of the risk based on the pathology causing the injury. In other words, for example, it can be alleged the surgeon ought to have warned of 'a two per cent risk of nerve injury causing paralysis or impairment of lower limb function'. If this is the warning that ought to have been given, embracing a number of possible mechanisms (ischemia, direct trauma etc), breach and causation can be asserted for any risk eventuating within this category of consequence.

A robust discussion with the patient/client is essential when discussing causation. On occasion, this may require assertive cross-examination of the client.[18] When your client is asked whether, if warned of the risk, they would have proceeded, the key is not their answer *per se*[19] but rather, what reasons they can give for this conclusion

This discussion needs to proceed with an appreciation that, in the context of warning of the relevant risk, a health professional might recommend (and reasonably so) proceeding via a particular mode of treatment. Common sense dictates that such a recommendation might be a powerful consideration in favour of proceeding (and likely to be heavily relied on by a defendant in any claim). Assessment is needed as to the prospects that the patient would have refused to accept such a recommendation (which might have been firmly put).

This hypothetical question – would the patient have refused a strong recommendation? – may need to be asked. Your client must attempt to answer this, while putting to one side their lived experience of the consequences of the risk. (It is debateable whether this can ever occur, but it must be attempted.)

It is important for you to assess what risks your client was informed of and consented to. It is unsustainable to argue a case based on non-disclosure of a very unlikely risk, even if of reasonably serious injury, when the patient/client confirms they were warned of a not-insignificant risk such as death from their anaesthetic, yet willingly proceeded. It is also useful to inquire about the treatment they have previously undergone (and consented to) and the risks they agreed to undertake in relation to earlier treatment.

CONCLUSION

'Failure to warn' cases should be approached with caution and, as with many medical claims, significant time and effort are often needed before making any sensible assessment of the prospects of such a claim. Unfortunately, it is often the case that while a breach of duty allegation is strong, the claim overall is too weak to pursue because of difficulties in establishing causation.

Nonetheless, there will remain a small but significant number of cases in which claims can and should be pursued for failure to meet health professionals' clear and important obligations to their patient. Hopefully, a review in a decade will show more successful outcomes for plaintiffs proceeding to trial in this area. ■

A SUMMARY OF SUPERIOR COURT 'FAILURE TO WARN' DECISIONS IN THE PAST 10 YEARS

Case	'Alleged' negligence	Outcome	Breach	Causation	Damage	Additional comments
Odisho v Bonazzi [2014] VSCA 11	Failure to warn of the risks of transexamic acid (a medication to treat abnormally heavy bleeding) causing thromboembolism.	Failed	No	No	Multiple pulmonary emboli	The plaintiff failed to establish that she would have declined the transexamic acid even if she was warned of the risk; and she failed to establish that the medication was in fact the reason for her thromboembolisms.
Wallace v Kam [2013] HCA 19	Failure to warn patient of two distinct material risks inherent in posterior lumbar interbody procedure; however, only one risk (the less serious) eventuated.	Failed	Yes	No	Bilateral femoral neurapraxia	The failure of the practitioner to warn of the risk of paralysis could not be the legal cause of the damage that materialised as it was found on evidence that the plaintiff would not have declined surgery if warned of such risks.
Waller v James [2013] NSWSC 497	Failure of gynaecologist to warn parents prior to conception of the hereditary aspects of the father's condition.	Failed	Yes	No	Child born with anti-thrombin deficiency and suffered stroke days after birth causing significant disabilities.	The court found that the doctor had failed to ensure that the parents were properly informed about the inheritance of the condition, and the court found that if the parents had been warned, they would not have followed through IVF procedure. However, the court held that the plaintiff failed to establish that the stroke (which caused the disabilities) was as a result of the inherited condition.
King v Western Sydney Local Health Network [2013] NSWCA 162	Failure to advise [and offer] chicken pox vaccine to plaintiff's mother when she contracted chickenpox while pregnant with plaintiff.	Failed	Yes	No	Plaintiff born with Congenital Varicella Syndrome	Defendant had duty to advise but was not liable as the plaintiff failed to establish a causal link between the administration of the vaccine and the prevention of the mother contracting chicken pox.
Combe v Katsaros [2011] SADC 93	Failure to warn plaintiff of risks of complex regional pain syndrome ('CRPS') and its sequelae.	Failed	No	No	CRPS and flexion contractures of fingers (consequently requiring amputation).	It was found that the defendant was not required to give a CRPS warning and that the plaintiff would have undertaken the proposed surgery regardless of whether he was warned of the risks in question. (He had had three successful earlier operations).
Harris v Bellemore [2010] NSWSC 176	Failure to warn plaintiff of risks of proposed bilateral leg lengthening surgery	Failed	No	No	Physical disabilities and incapacitating psychiatric disability.	Although a breach of duty of care was found in the way the surgery was performed, the court held that even if the doctor gave inadequate warning of potential complications of particular risks relating to bone formation, the plaintiff would have proceeded to undergo the surgery.

Case	'Alleged' negligence	Outcome	Breach	Causation	Damage	Additional comments
Hammond v Health [2010] WASCA 6	Failure to warn of risks associated with allowing mesh to remain in place after surgery.	Failed	No	No	Infection and fistula due to mesh remaining post-surgery.	No duty to inform of risk of leaving mesh post-operatively, and normal medical practice was not to warn of such risks of allowing the mesh to remain in place.
Rooke v Minister for Health [2009] WASCA 27	Failure to warn of the risk of post-operative complications including palmar hypersensitivity (which eventuated).	Failed	No	No	Palmar hypersensitivity.	It was not established that the medical practitioner failed to warn of the post-operative complications, and it was found that the plaintiff would have undergone the proposed surgery even if warned of the risks. Further, it was found that there was not a sufficient link between the complication and the surgery.
Kerr v Minister for Health [2009] WASCA 32	Failure to warn plaintiff of the risks (of seizures) of post-operative prescription of pethidine.	Failed	Yes	No	Post-operative seizures leading to sternum and spine injuries as a result of subsequent CPR.	It was established that the anaesthetist breached his duty of care to warn the plaintiff of the material risk inherent in administering pethidine, but the court held that the plaintiff failed to prove the pethidine dosage materially contributed to seizure.
Hookey v Paterno [2009] VSCA 48	Failure to warn the plaintiff of the risks of nerve damage from oral surgery	Successful	Yes	Yes	Permanent nerve damage.	It was found that the surgeon failed to warn the plaintiff of the risks of the proposed surgery and if the plaintiff had been warned, she would not have proceeded with the surgery.
Elbourne v Gibbs [2006] NSWCA 127	Failure to warn of risk of nerve injury from hernia surgery.	Successful	Yes	Yes	Gross swelling of scrotum and chronic pain resulting from nerve entrapment.	The failure to warn the plaintiff of risks combined with materialisation of such risks is sufficient to satisfy the test of causation.
Fisher v Stapley [2005] WASCA 16	Failure to warn of vision loss risk associated with ENT surgery.		Yes	Yes	Vision damage	The trial judge was correct in finding breach of duty of care and such breach caused the plaintiff's injuries. In addition to the claim of failure to warn, the plaintiff claimed the surgeon was negligent in performing the surgery and submitted a notice of contention. The Court of Appeal held that the trial judge should have found (but didn't) that the surgeon was negligent in the conduct of the surgery and upheld such notice of contention.

Farrell v CSL [2004] VSC 308	Failure to inform/warn concerning the risk of contracting Creutzfeldt-Jakob disease (CJD) from HPG treatment	Failed	No	No	Psychiatric injury from being exposed to risk of contracting CJD.	Plaintiff's psychiatric condition not caused by any negligence by defendants, as such risk was not recognised at the time (thus no breach). Rather, her condition was caused by her failure to accept advice that the treatment was unlikely to cause CJD.
Chopra v Maxwell [2003] QSC 188	Failure to warn plaintiff of serious side effects of contraceptive pill.	Failed	No	No	Cerebral Vascular Accident	As the prescription for the pill was for a very short term, there was no duty to distinguish between the non-serious and serious potential side-effects (risk of stroke was very low). Further, cessation of the pill would not have altered the coagulable state of the plaintiff's blood and the developing stroke could not have been anticipated/prevented or reduced in severity.
Di Carlo v Dubois & Ors [2003] QSC 204	Failure to advise plaintiff of the risks of undergoing radiology contrast and injection of medium.	Failed	Yes	No	Severe reaction to contrast medium during radiological examination.	The court held that only the 5th defendant (specialist neurosurgeon) had breached his duty, but found that the plaintiff did not discharge the onus of proving he would not have undergone the procedure if he had been directly warned of the risks associated.

Notes: **1** [1992] HCA 58; (1992) 175 CLR 479. **2** *Bolam v Friern Barnet Hospital Management Committee* [1957] 1 WLR 582. **3** See *Rogers* at [16]: such risks being defined as *'material risks'*. The test is broader if Kirby J's comments in *Rosenberg v Percival* [2001] HCA 18 at [149] are followed and perhaps narrower if Gummow J's comment at [77] is the focus: risks the patient would *'seriously consider/weigh'*. **4** Via Barnet using the search parameters 'failure to warn' and the last 10-year period specified. **5** Though this does follow automatically in cases in which no breach occurred. **6** It is appreciated that several states have enacted provisions in their civil liability legislation seeking to amend the duty to warn. To date, as far as I am aware, no case law has developed explaining how such provisions vary, if at all, the common law position following *Rogers* etc. **7** Noting the authorities on this point: see, for example, *G & C v Down* [2008] SADC 135 at [140]. **8** You need clear instructions and careful review of the records relating to the 'consent process' for such assessment. **9** See, as a recent example, the Victorian Court of Appeal's potential preparedness to overturn the trial judge's finding on such point in *Odisho v Bonazzi* [2014] VSCA 11. **10** In regard to this distinction, see, for example, *Wallace v Ramsay Healthcare* [2010] NSWSC 518 at [49]. **11** It is interesting to consider the likely outcome in *Rogers*, if it were heard today, with a CLA legislative framework and the case law developed in relation to causation questions. I don't think it is a foregone conclusion that causation would be made out; the risk after all was small (1 in 14,000) and the 'upside' of the operation was significant (substantial improvement of sight in the almost blind 'good' eye). On balance, from what can be gathered from reading the case, Ms Whitaker would have had reasonable prospects, but by no means a lay-down *misere*. **12** The health professionals' difficulties and omissions more often relate to the less likely or rare risks, which they do not consider ought to influence the patient's decision. **13** While medical paternalism is clearly inappropriate, it is still true that in most instances, the health professional's view will reflect what is truly in the patient's best interests from a purely objective health perspective. **14** See *Wallace v Kam* [2013] HCA 19 at [20] and as to the special treatment of such category of cases, compared to negligent diagnosis, see *Paul v Cooke* [2013] NSWCA 311 at [93] and [98]. **15** Whatever debate there may have been before, it appears clear there is now no such onus reversal given the terms of the various states' civil liability legislation. **16** Bearing in mind the sensible approach already adopted in common law cases, see *Rosenberg* per McHugh J at [33] and, more bluntly, in *Hoyts Pty Ltd v Burns* [2003] HCA 61; per Kirby J at [54]. **17** See note 14, above. **18** If you don't, you can count on the fact someone else will, down the track! **19** See *Odisho v Bonazzi* [2014] VSCA 11 for how unconvincing and pointless such a bald assertion alone, without foundation, can be.

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