It's Just a Jump to the Left - and then a Step to the Right: Developments post *Rogers v Whitaker* in the Law Relating to Failure by a Medical Practitioner to Advise of Risks

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> 'Medical Law used to be fun. All you had to do was read lots of strange American cases, the odd Commonwealth decision, and maybe some English 19th century cases on crime. Then you could reflect that none of these was relevant and get on with the fun of inventing answers.'[1]

Rogers v Whitaker[2] marked a defining moment in establishing a distinctive Australian medical jurisprudence. It represented a point of departure for Australian law from the shackles of the 'doctor centred' Bolam test - at least in respect of failure-to-advise cases. It was not so much a case of inventing answers as drawing upon experience from other jurisdictions, and applying a liberal dose of common sense.

Developments since *Rogers v Whitaker* have largely gone unreported. These developments severely limit the scope of the High Court's decision and are thus worthy of closer attention. This article aims to explain the limiting factors on the High Court's decision in *Rogers v Whitaker*, and to raise the spectre of one worrying development.

This article is divided into four sections. In the first section, the various heads of medical liability will be explored. The aim is to demonstrate how central the action in negligence is to an aggrieved patient. The law of negligence as it stood before *Rogers v Whitaker*, as well as the changes wrought by that case, will next be explored. In the third section, unreported cases dealing with an alleged failure to disclose material risks will be analysed. This part of the paper will highlight the retreat from what might have been thought of as a far reaching High Court decision. Problems facing potential plaintiffs will be highlighted. The final section of the article will consider a worrying

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1 Kennedy I, 'The Patient on the Clapham Omnibus', (1984) 47 *MLR* 454.

2 (1992) 175 CLR 479.

development from New South Wales which threatens to undermine the internal consistency of the principles expounded by the High Court in *Rogers v Whitaker*.

Part I - Grounds of Potential Liability

The practise of Australian medicine is regulated not only by codes of ethics, but also by intervention of the law. The law views the interaction between doctor and patient as potentially giving rise to liability in four fields:

- Liability for Breach of Contract
- Liability for a Breach of the Fair Trading Act
- Liability for Battery
- Liability for Negligence

It might legitimately be asked, then, if *Rogers v Whitaker* only alters the law in as much as negligence is concerned, what is all the fuss about? The answer lies in the difficulties faced by aggrieved patients who try to sue outside of negligence. In reality, though patients may have other causes of action open to them, they are most likely to pursue an action in negligence.

(i) Contract

It is clear that the relationship between doctor and patient is contractual in nature,[3] and that the Medicare system in Australia has not altered this. The contract between doctor and patient may even arise in the absence of agreement on fees or duration of service.[4]

If there is a contract between doctor and patient, what are the terms of such a contract? Liability in contract may arise in circumstances in which a patient alleges that a doctor breached a term of the contract between doctor and patient by failing to cure the patient. In the absence of an express promise by the doctor that he will cure the patient, the potential for liability has been severely circumscribed by decisions of the English Court of Appeal. In *Greaves and Co*

3 *Sidaway v Board of Governors of Bethlem Royal Hospital* [1985] AC 871 at 904 per Lord Templeman.

4 Meredith C, *Malpractice Liability of Doctors and Hospitals*, Carswell, Toronto, 1956.

(Contractors) Ltd v Baynham Meikle and Partners[5] Lord Denning MR suggested that, in respect of a professional man:

> 'The law does not usually imply a warranty that he will achieve the desired result, but only a term that he will use reasonable care and skill. The surgeon does not warrant that he will cure the patient. Nor does the solicitor warrant that he will win the case.'[6]

Lord Denning's statement was applied by the Court of Appeal in two later cases - both involving failed sterilisations. The first, *Eyre v Measday*,[7] involved a sterilisaion operation performed on a woman. The second, *Thake and Another v Maurice*,[8] involved a sterilisation operation performed on a man. In both cases, the plaintiffs were unsuccessful in their action for breach of contract. The Courts were unwilling to imply a term (or a warranty) that the doctor promised his operation would be a success. It would seem that the only patients likely to be successful in maintaining contract actions are those who could point to an express promise made by their doctors or the small number who, like the patient referred to in *Chatteron v Gerson*,[9] can state that the doctor breached his contract by performing the wrong operation.

(ii) Fair Trading Act

Actions for a breach of the *Fair Trading Act* in the circumstances of a doctor-patient interaction are, as yet, largely untested, though there has been academic commentary on the possibility.[10] In the absence of a concrete application of the Act to a doctor-patient interface, prospects for an aggrieved patient are, at best, uncertain.

(iii) Battery

A doctor who, without consent, applies force to a patient, without obtaining that patient's consent, commits a battery. The doctor

5 [1975] 1 WLR 1095.

6 Id, at 1100.

7 [1986] 1 All ER 488.

8 [1986] 1 QB 644.

9 [1981] QB 432. In the case, reference is made to a patient admitted for a tonsillectomy who, in error, is circumcised instead.

10 See e.g. 'Aggrieved Patients Who Claim They Were Not Told: A New Avenue of Redress?' (1990) 20 *UWALR* 489.

commits a battery as much as the mugger on the street commits a battery or the rapist in the bushes commits a battery. The unfortunate connotations perhaps explain the reluctance of the courts to hold doctors liable for what may be thought of as a beneficial act (viz, the administration of medical treatment).

It is clear that if a doctor performs a different type of operation than that consented to, a battery will have been committed. So, in *Murray v McMurchy*,[11] a doctor was liable in battery where he performed a tubal ligation on a patient when he had only consent to perform a cesarean section on her. He was held liable notwithstanding that the performance of the operation was considered convenient and clinically indicated.

A similar result follows the circumstance in which a patient who is unable presently to communicate but who has, at a previous time while competent, indicated that he/she did not wish to have certain treatment. So in *Malette v Shulman*,[12] where a patient who was admitted to the emergency room was found to have on her a card proclaiming her to be a Jehovah's Witness and stating that in no circumstances did she want a blood transfusion, that expression of non-consent had to be recognised. A doctor who administered a blood transfusion to her was found liable in battery.

Outside of the above cases, prospects are slim for a patient sueing his or her doctor for battery. One way to succeed in such an action would, of course, be to allege that the patient did not give a valid consent to the procedure performed by the doctor. This may be relatively easy to prove in the case of children or the intellectually disabled, but is considerably more difficult for those of full capacity.

The locus classicus is the case of *Chatterton v Gerson*.[13] There a woman who had experienced pain around the region of a post-operative scar was referred to a specialist in pain relief. He carried out an intrathecal block on her. Such a procedure was designed to block the messages from the nerves to her brain. Following the procedure, the plaintiff suffered a loss of sensation in her leg, and such severe pain in the area of the scar that she could not bear having clothing in contact with it. She sued the defendant alleging that his failure to disclose the possibility of the side-effects she sufferred meant that she had not given a valid consent to treatment since she did not under-

11 (1949) 2 DLR 442.

12 (1990) 67 DLR (4th) 321.

13 Note 9 above.

stand the risks of the treatment. Bristow J, in dismissing Mrs Chatterton's action for battery noted that once a patient has been informed in broad terms of the nature of the procedure and has given consent to the procedure, then that consent is real. *Chatterton v Gerson* has been followed in Australia in *Rogers v Whitaker*.[14]

Part II - Negligence - the Law Prior to *Rogers v Whitaker*

If a duty is owed by one party to another, that duty is breached and damage is caused, then liability will flow in negligence. It is clear that a doctor owes his/her patient a duty of care. The scope of a doctor's duty to his/her patient encompasses three different obligations: the obligations to diagnose, to advise and to treat.[15]

It had been generally accepted (with some minor exceptions outlined below) prior to *Rogers v Whitaker*, that all aspects of a medical practitioner's practise were to be examined according to whether the practise accorded with what was acceptable within that profession. The classic statement is to be found in the case of *Bolam v Friern Hospital Management Committee*.[16] That case concerned a negligence action brought by a patient who had undergone Electro Convulsive Therapy. The patient alleged that the failure to administer a muscle relaxant or to apply manual restraints before the ECT was administered was negligent, and had caused fractures.

In directing the jury as to negligence, Justice McNair noted that in the case of someone professing special skill the proper test was that of the ordinary skilled man exercising or professing to have that special skill. In the case of 'a medical man', His Lordship stated that negligence meant:

> 'a failure to act in accordance with the standards of reasonably competent medical men at the time ... [provided that] it is remembered that there may be one or more perfectly proper standards; and if he conforms with one of those standards, then he is not negligent.'[17]

The latter gloss noted by Justice McNair proved critical in later cases. In *Maynard v West Midlands Regional Health Authority*,[18] a patient was suspected of suffering either from tuberculosis or Hodgkin's disease.

14 Note 2 above.

15 Id, at 489 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ.

16 [1957] 1 WLR 582.

17 Id, at 586-587.

18 [1984] 1 WLR 634.

Before waiting for a test which would have indicated which of these two were the cause of the patient's symptoms, the two consultants performed an exploratory operation on the patient. As a result, the patient suffered damage to her vocal chords. She was unsuccessful in her action for negligence, the House of Lords noting that it was not for the court to choose between competing versions of acceptable medical practise provided that the consultants had chosen to follow one of them.

In *Sidaway v Governors of Bethlem Royal Hospital*,[19] the House of Lords focussed squarely on the question of a failure to advise of a risk. There the plaintiff, who had for some time experienced pain in her neck and shoulders, agreed to undergo an operation on her spinal column. The operation was competently performed but a known risk materialised and she became severely disabled. At no time prior to the operation had the surgeon discussed with the plaintiff the possibility of the risk materialising. She sued, alleging that the surgeon's failure to advise her of the risk of paralysis amounted to negligence.

Although the House of Lords dismissed the plaintiff's action, Lord Bridge put a gloss upon the application of the Bolam standard to negligence actions. Although the determination of whether disclosure of a risk was primarily a matter for professional judgment, his Lordship suggested that where there was a conflict of opinion, the court would have to determine the appropriate standard.

In Australia, the Bolam standard came under even greater strain in South Australia.[20] In *F v R*,[21] the Full Court of the South Australian Supreme Court had to consider whether a doctor who failed to advise of the possibility that a tubal ligation may not be successful, should be liable in negligence. In holding that the doctor was not negligent, the Court was not prepared simply to defer to medical judgment about what should have been disclosed. The matter of whether some risk should be disclosed to a patient was not a question of whether the medical practitioner's conduct:

> 'accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the

19 Note 3 above.

20 There were similar 'dissents' expressed in New South Wales: see for example *Albrighton v Royal Prince Alfred Hospital* [1980] 2 NSWLR 542 and *E v Australian Red Cross* (1991) 27 FCR 310.

21 (1983) 33 SASR 189.

> law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.'[22]

Two years later the Full Court of South Australia in *Battersby v Tottman*[23] had to consider an action in negligence brought by a patient who had suffered eye damage as a result of the prescription of high doses of meleril. The patient, who suffered from reactive depression, was not told of the risk of damage to the retina which was posed by the ingestion of meleril. The defendant, Dr Tottman gave evidence that he did not warn of the risk of eye damage because he was afraid of the adverse effect on the patient that any warning (or monitoring of the effect of the drug) might have on the patient, in particular, the risk of hysterical blindness. The Court followed its own prior decision in *F v R* but held (Zelling J dissenting) that the real risk of injury to the plaintiff had disclosure taken place justified the defendant in not disclosing the risk of eye damage. Zelling J, though dissenting, was just as scathing of the doctor-centred standard. He noted that arguments judging whether disclosure should have been made to a patient based upon what a reasonable doctor would do 'have no place in relation to the medical world today.'[24]

After *Rogers v Whitaker*, the question of whether any part of a doctor's practise was negligent was no longer to be determined solely by what other doctors were doing, though the High Court noted that evidence might be highly persuasive in the case of the doctor's duty to diagnose or treat. The High Court held there was something quite distinctive about the duty to advise. That what was involved was not the exercise of medical training, and that accordingly a different test should apply.

In 1988, Manderson had suggested that there probably was a difference between, on the one hand, medical advice, and on the other, diagnosis or treatment. Diagnosis or treatment is performed on the patient. Medical advice by contrast, is applied to the patient to enable him or her to make an informed decision.[25] Malcolm notes:

22 Id, per King CJ at 194.

23 (1985) 37 SASR 524.

24 Id, at 537.

25 Manderson R, 'Following Doctor's Orders: Informed Consent in Australia', (1988) 62 *ALJ* 430.

> 'the information supplied by the doctor is, therefore, the basis for the decision which is, to a large extent, the patient's only moment of "self determination".'[26]

The Law Reform Commission of Victoria, in their discussion paper on Informed Consent to Medical Treatment,[27] had suggested that the starting point should be the protection of patients' rights. Malcolm, citing the discussion paper and Manderson notes:

> 'thus, it would seem reasonable for the courts to determine the standard of information disclosure on the basis of what is necessary to protect those rights, and not on what the medical profession considers appropriate.' [28]

Rogers v Whitaker - the Jump to the Left

The plaintiff in *Rogers v Whitaker* was a 47 year old woman. She was preparing for a return to the workforce and wanted to know if the sight in her right eye could be improved. Her right eye had been damaged by a stick when she was nine. Mrs Whitaker was referred to an opthalmic surgeon, Mr Rogers who told her that he could improve both the appearance of her eye (which had scar tissue on it) and her sight in that eye. Mrs Whitaker was concerned that the surgeon might accidentally operate on her 'good eye' and suggested that a patch be placed over her good eye before surgery, so that the surgeon could be sure he was operating on the correct eye. She also asked 'incessant' questions about the procedure and possible complications.

The surgery was performed on Mrs Whitaker. The surgery was performed competently and without negligence. Unfortunately, a rare complication, sympathetic opthalmia, developed in Mrs Whitaker's left eye. The operation did not improve the sight in Mrs Whitaker's right eye, and she became almost totally blind. Mrs Whitaker sued Mr Rogers claiming that Mr Rogers' failure to advise her of the risk of sympathetic opthalmia was negligent.

At first instance, evidence was led which indicted that the risk of sympathetic opthalmia was 1 in 14,000. Mr Rogers submitted that he was not negligent since he had acted in accordance with a responsible body of medical opinion. He noted that while Mrs Whitaker had

26 Malcolm D, 'The High Court and Informed Consent: The Bolam Principle Abandoned', (1994) 2 *Tort Law Review* 81.

27 Law Reform Commission of Victoria, *Informed Consent to Medical Treatment*, Melbourne, 1987.

28 Malcom D, note 26 above, p 93.

asked many questions, she had not specifically asked whether her left eye could be harmed by the surgery.

The trial judge found for Mrs Whitaker, as did the Court of Appeal. The High Court dismissed an appeal by Mr Rogers.

In finding Mr. Rogers liable the High Court noted firstly, that a failure to communciate information about risks would sound in negligence only, and not in battery. While the Court acknowledged the existence of a single comprehensive duty of care owed by a doctor to a patient, the High Court suggested there was a clear distinction between, on the one hand, a doctor's obligation to diagnose and treat, and a doctor's obligation to advise of material risks. In the former, the patient's role:

> 'is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill.'[29]

In this field, the Court acknowleged that evidence of professional practice would have 'an influential, often a decisive role to play.'[30] On advice giving obligations of the doctor, the Court noted that the patient's choice whether to undergo a particular procedure or not calls for decision by the patient on information known only to the medical practitioner. Thus:

> 'it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession.'[31]

By what standard then, should information disclosure be judged? The High Court determined that a medical practitioner should disclose to a patient all 'material risks'. A risk was material if a medical practitioner knew, or ought to have known that a reasonable patient would attach significance to it, or that the medical practitioner knew or ought to have known that this patient would attach significance to it. The High Court granted an exemption from disclosure where disclosing the risk of treatment would be detrimental to the health of the patient (the therapeutic exception). In view of Mrs Whitaker's expressed concerns about her 'good eye' and her incessant questioning,

29 *Rogers v Whitaker*, note 2 above, at 489 per Mason CJ, Brennan, Dawson, Toohey and McHugh JJ.

30 Ibid.

31 Ibid.

Mr Rogers ought to have known that the risk of blindness was a material risk for Mrs Whitaker.

Part III - Developments After Rogers v Whitaker - The Step to the Right

Rogers v Whitaker, though warmly welcomed by most non-medical commentators,[32] caused significant apprehension among medical practitioners. Developments after *Rogers v Whitaker* should hopefully calm some of the fears of practitioners.

(a) The Causation Issue

One of the matters that seems to have been taken for granted, or not clearly articulated in most failure-to-advise cases, is the question of causation. It will be recalled that three elements must be proved to successfully maintain an action in negligence. First, that a duty exists. Second that that duty has been breached. Third, that the breach of duty has caused damage. In most cases of medical negligence, the third element will be obvious - the medical practitioner, for example, who leaves foreign matter inside a patient and the patient gets sick as a result.[33] Leaving foreign matter inside a patient (a negligent act) *causes* the illness (damage).

In failure-to-advise cases, the causation issue is not quite as obvious. It is not sufficient that the plaintiff gives evidence that there was a material risk that the doctor should (but didn't) tell him or her about. The plaintiff must also demonstrate that this failure on the part of the medical practitioner caused some sort of compensable loss. The normal way to demonstrate loss is for a plaintiff to say that had he/she known of the risk of the procedure, he/she would not have elected to have the procedure. In other words, the damage caused is whatever damage is occasioned by the materialisation of the risk. If the plaintiff had been informed of the risk, he/she would not have had the procedure, the risk would not have materialised for the plaintiff, and so the plaintiff would have been in a much better position than he/she presently is.

32 See e.g. Chalmers D, and Schwartz R, '*Rogers v Whitaker* and Informed Consent in Australia: A Fair Dinkum Duty of Disclosure', (1993) 1 *Med L Rev* 139; Keown J, 'Burying Bolam: Informed Consent Downunder', [1994] *Camb LJ* 16.

33 See, for example, *Dryden v Surrey County Council and Stewart* [1936] 2 All ER 535.

Is causation a subjective or objective test? That is to say, is it a question of whether a reasonable patient, properly informed, would not have undergone the procedure (objective test); or whether this patient had he/she been properly informed would not have undergone the procedure (subjective test)? The matter was not addressed by the High Court, though there was authority to suggest that a subjective test should be used.[34]

If the test is subjective, it becomes very easy for a patient, once the first two elements of negligence are proved, to satisfy the third element. Simply giving evidence that he or she would not have consented to the procedure had he/she known of the risks, would be enough. Such would appear to have been the case in the unreported judgment in *Shaw v Langley*.[35] In that case the plaintiff was a 29 year old who, following the birth of her child some nine years earlier, experienced a reduction in the size and shape of her breasts. The court found that she was an otherwise healthy woman who was fond of outdoor activities.

Mrs Shaw consulted her general practitioner about the possibility of a breast enlargement. Her GP referred her to the defendant. The defendant, the judge found, failed to warn Mrs Shaw of the risk of capsulation, altered sensation in her breasts and scarring. Discussions the plaintiff had with the defendant left her with the impression that the operation was a straightforward procedure.

After the operation, Mrs Shaw experienced scarring on her breasts. Her breasts were left asymmetrical and her nipples faced in opposite directions. The implants became infected, requiring further surgery.

Mrs Shaw sued the defendant on the basis, inter alia, that he had failed to warn her of the risks of the procedure. She was awarded over $30,000.

A similar result occurred in the unreported case of *Tekanawa v Millican*.[36] There a mother of four who, the trial judge found, 'obtained satisfaction from her attractiveness and fitness' underwent an abdomnioplasty. The defendant surgeon failed to inform her of the risk of unsightly scarring and post-operative pain. In the end result, the

34 *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553; *Gover v State of South Australia* (1985) 39 SASR 543.

35 Unreported, Pratt DCJ, District Court of Queensland, 24 November 1993. Details of this case may be found in Croft P, 'Informed Consent Comes Home to Roost', (1994) 2 No. 7 *Australian Health Law Bulletin* 86.

36 Unreported, Botting DCJ, District Court of Queensland, 11 February 1994. See generally Croft P, ibid.

plaintiff experienced both - the latter requiring medication before the plaintiff could sleep at night. She was successful in an action against the defendant for failing to inform.

The Court accepted the plaintiff's evidence in both *Shaw's* and *Tekanawa*'s cases that, had they known of the risks attendant to the procedures, they would not have undergone the procedures. Given that both cases involved women who were so concerned about their appearance that they were motivated to undergo surgery to correct it, the result in hardly surprising. What, though, of the case of plaintiffs who give evidence that they would not have undergone the procedure, but objective facts suggest otherwise?

In interpreting causation post *Rogers v Whitaker*, the Courts seem increasingly to be taking a more objective view of causation. In particular, they will examine closely any suggestion that a patient, had he/she been informed of the risks, would not have consented to the procedure, if that statement conflicts with other facts.

Typical of this cautious approach is the unreported case of *Bustos v Hair Transplant Pty Ltd and Peter Wearne*.[37] That case concerned a 33 year old man concerned about his hair loss. The man's uncle, who also suffered from a receding hairline, underwent a procedure called a 'Juri Flap'. The plaintiff contacted the defendant hair transplant clinic and arranged to have the Juri flap procedure performed on him. Following the procedure, the plaintiff claimed he suffered from excess skin on one side of his face, headaches, severe pain, a psychiatric disorder which resulted in the breakdown of his marriage and an inability to work.

Judge Cooper accepted that the risks which materialised were material risks. The defendant knew that the plaintiff was concerned about his appearance, and that he managed a restaurant. He accepted the defendant's evidence that he had, in fact, warned the plaintiff about the risks of the procedure. Judge Cooper preferred the defendant's evidence in this respect, over the evidence given by the plaintiff. The plaintiff gave evidence that the defendant had not warned him of material risks and that had he been so warned, he would not have undertaken the procedure.

37 Unreported, Cooper DCJ, District Court of New South Wales, 20 December 1994. Details of this case may be found in Campbell F, 'Causation and the Failure to Advise of Risks Associated with Medical Procedures', (1995) 3 No. 6 *Australian Health Law Bulletin* 1.

The Judge did not accept the plaintiff's evidence on this last matter. He suggested that the plaintiff's misfortunes had coloured his remembrance of events. The judge described the plaintiff as being keen, if not desperate to have the procedure, and noted that the picture in the plaintiff's mind of his uncle's good result following the procedure had overborne the knowledge of the risks. Accordingly, Judge Cooper found that the plaintiff could not satisfy the causation element of negligence.

A similar caution in respect of the subjective approach to causation in failure to advise can be seen in the unreported case of *Berger v Mutton*.[38] In that case the plaintiff was a 48 year old nurse who suffered recurring abdominal pain and rectal and vaginal bleeding for a period of two years. Concerned that she might have cancer, she consulted the defendant who recommended a dilation and curettage as well as a diagnostic laparoscopy.

The procedures were performed without negligence, but the plaintiff's bowel was pierced necessitating suturing and a longer stay in hospital. The plaintiff claimed she was not warned of the risk of perforation of the bowel and that, as a result of the perforation, she had endured pain, a longer hospital stay, nightmares and now had an unsightly scar.

The plaintiff claimed that the defendant had failed to warn her of the risk of the procedures, that she had no knowledge of such risks, and that if she would have been informed, she would not have undergone the procedures.

The trial judge doubted whether the plaintiff could claim she did not know of the risks of the procedure. She had substantial theatre and oncology experience and had previous personal experience of a similar procedure. Judge Twigg also doubted her evidence concerning whether, had she been informed of the risks, she would not have had the procedures. He found that the plaintiff had a real fear that she might have cancer and, from her own professional career was well aware of the devastating effects such a disease might have. He found that she was determined to have the procedures to rule out the possibility of cancer.

In both of the above cases it was clear that the medical practitioner concerned had in fact given a warning as to risks associated with the treatment. Comments by their Honours as to whether a plaintiff's

38 Unreported, Twigg DCJ, District Court of New South Wales, 22 November 1994. See generally Campbell F, ibid.

statement as to causation had to be taken at face value were, of necessity then, merely obiter.

In the unreported case of *Causer v Bell*,[39] by contrast, the medical practitioner conceded that he had not given a warning of the risk which had materialised and the plaintiff alleged that, had such a warning been given, she would not have consented to the treatment. The plaintiff in that case had experienced some problems with her periods and was advised to undergo a hysterectomy. The surgeon she consulted warned her of the risks associated with general anaesthetic, but did not mention the risk of a fistula developing. Prior to the operation being performed, the plaintiff underwent a short course of hormone treatment. During that time, she delivered a list of questions to the surgeon, asking about such things as lifestyle changes and how soon after the operation she could resume leisure activities.

After her operation, a fistula developed. The risk of such a complication was estimated to be somewhere between 0.1% and 0.01%. The plaintiff gave evidence that if she had known of the risk of the fistula, she would not have consented to the treatment. The Court found the plaintiff's statement in this regard to be 'tainted by hindsight ... coloured and unreliable.' The Court was conscious of the fact that the plaintiff had been so bothered by her heavier periods that she had consulted the defendant, that she did not want the other treatment alternatives because they 'would not have been conducive to the type of lifestyle she was seeking.' Accordingly, the plaintiff was unable to prove causation.

(b) The magnitude of the risk

In *Rogers v Whitaker*, the High Court found a surgeon liable when he failed to disclose a risk estimated as being a risk of 1 in 14,000. Some may have thought then, that any risk of treatment which was greater than this needed to be disclosed by a medical practitioner to a doctor, in order that he might escape liability for failing to disclose. Thinking such a thing would be to underestimate the importance of the difference between a serious risk and a material risk.

The importance of identifying a material risk can be seen most clearly in *Bell's* case. There, although the risk of a fistula developing was relatively high (at least when compared with the risk of sympathetic

39 Unreported, Gallop J, ACT Supreme Court, 14 November 1997.

opthalmia in *Rogers v Whitaker*), the court decided it was not a material risk. The Court decided the risk was not material because the consequences of developing a fistula were relatively minor and, with treatment, the fistula would resolve itself. The questions submitted by the plaintiff to the defendant in that case about the operation were not concerned with possible medical complications and the plaintiff did not discuss the answers to those questions with the defendant. The Court noted:

> 'this tends to illustrate that there was no indication that the plaintiff would be likely to attach significance to the risk of a fistula developing, nor that the defendant was or should have been reasonably aware that she would.'

The finding in *Bell's* case is explainable by reference to a little-cited part of the High Court's judgement in *Rogers v Whitaker*. The High Court approved a statement made by King CJ in *F v R* that in deciding whether a doctor should have known that a risk was of particular significance to a patient the following factors were relevant: the nature of the matter to be disclosed; the nature of the treatment; the desire of the patient for information; the temperament and health of the patient and 'the general surrounding circumstances'. With respect, the first, second and last of these guiding principles are so vague as to be unhelpful.

In the unreported case of *Teik Huat Tai v Saxon*, the Full Court of Western Australia built upon the principles first expounded by King CJ in *F v R*. Justice Ipp suggested that the significance which is likely to be attached to risks is dependent upon the magnitude of the risk, the nature of the potential harm, the need for the treatment itself (ie are alternatives available) as well as the physical and mental state of the patient. Thus:

> 'the possible remoteness of the risk has to be weighed against the possible gravity of the possible consequences. The more remote the risk, the less the need to impart information concerning it; on the other hand the more serious the possible consequences, the greater the need to make an appropriate disclosure. The less urgent and critical the need for the procedure, the greater the need for advice as to possible risks involved and as to possible different means of treating the problem.'

The Full Court's statement in *Saxon's* case provides a workable and easily understood formula to guide practitioners. It is submitted that Ipp J's statement represents little more than the calculus of negligence - a formula familiar to tort lawyers when they are assessing whether any particular conduct was negligent.

Part IV - Causation Revisited - The Potential for Doctor's Nightmares

The only matter that should give medical practitioners cause for concern, in the wake of *Rogers v Whitaker*, is the recent unreported decision of the New South Wales Court of Appeal in *Chappel v Hart*.[40] That case concerned a woman who underwent surgery in order to remove a pharyngal pouch on her oesphagus. When she attended the defendant surgeon before the procedure she said that she was concerned as 'she did not want to end up like Neville Wran.' The surgeon warned her of some of the risks of the procedure, but not the risk of mediastinitus. This rare complication ensued, and the plaintiff sued the defendant for failing to advise a material risk.

The difficulty the plaintiff faced in this case was that she was unable to give evidence that, had she known of the risk, she would not have undergone the procedure. She said that she would have postponed the procedure, and perhaps had the procedure done by another, more experienced surgeon. Evidence was led at the trial that the procedure to remove the pharyngal pouch had been performed without negligence and that mediastinitus could occur without the surgeon being negligent.

At first instance, Ms Chappel was awarded damages for the doctor's failure to advise of the risk. The Court of Appeal upheld the award of damages.

The court's decision in *Chappel v Hart* is hard to reconcile with the need to prove causation - a critical element of liability in negligence. Since Ms Chappel would have had the operation, whether she had known of the risk or not, and the complication she was concerned about could occur in a procedure conducted even by the most careful and experienced of surgeons, it is hard for her to prove that she has lost anything. The only possible loss that she might have experienced is the time lag between deciding not to proceed with one surgeon, and employing the services of another. During this time she would not be suffering from the symptoms of mediastinitus (not yet having had the operation). It is suggested that, with respect, *Chappel v Hart* is bad law, and ought not to be upheld on appeal.

40 Unreported, Court of Appeal (NSW), 24 December 1996.

Conclusion

Rogers v Whitaker caused a scare amongst the medical community. The benefit of hindsight suggests that the panic was unnecessary, though the Court of Appeal's decision in *Chappel v Hart* gives pause for thought. The High Court has established a workable test for medical negligence which seems to be functioning fairly. It is submitted that in considering the appeal in *Chappel v Hart*, the High Court should be concerned to protect the consistency of the law of negligence.