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“Liability for Negligent Failure to Disclose Medical Risks”
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"In jure non remota causa, sed proxima, spectatur": Lord Bacon, first "Maxim of the Law".

Introduction

The affirmative duty to disclose medical risks was first imposed upon medical practitioners by the United States Court of Appeals for the District of Columbia in 1972 in Canterbury v Spence under the doctrine of "informed consent". In 1992, in Rogers v Whitaker, the High Court of Australia incorporated the new duty, though apparently not the doctrine, into the Australian law of negligence. In 1998 the case of Chappel v Hart provided the High Court with an opportunity to discuss the issue of causation in the context of liability for negligent failure to disclose medical risks. Issues of breach and causation involving duty to warn were also the subject matter of the High Court's decision in Rosenberg v Percival.

This column will discuss these cases, arguing that the judiciary has effectively created a novel legal interest – the invasion of pure autonomy within the context of a professional medical relationship. It will also argue that the Donoghue v Stevenson cause of action cannot provide a proper epistemological foundation for protection of this new interest. Rather, the liability for invasion of pure autonomy through negligent failure to disclose medical risks should form a separate category of case pertaining to obligations to advise stemming from a professional relationship. These obligations would not be limited to the patient-doctor relationship, but would include all relationships that fall within the legal definition of a "professional relationship". A professional relationship could be generally defined as one in which one party has or professes to have some specialist knowledge, training and skills, while the other party is especially vulnerable or dependent on the advice of the professional.

It needs to be noted that, apart from professional relationships, there exists an obligation to advise in fiduciary relationships and some statutory relationships. In Bennett v Minister of Community Welfare, the plaintiff, who was at the time effectively a ward of State, was dependent on the defendant (in his statutory office as guardian) for information and advice regarding the right to recover damages under an accident insurance claim for the loss of four fingers of his left hand. Mason CJ, Deane and Toohey JJ stated that the defendant's common law positive duty to procure independent legal advice with respect to the
plaintiff's right to bring an action for damages for personal injury arose independently of the fiduciary duty. Their Honours, however, did not explain the basis for the affirmative duty at common law. Unlike relationships between wards and their guardians, clients and lawyers or bankers, professional relationships between patients and doctors are regarded in Australian law as confidential, but not fiduciary, in nature.

Critique of the present position regarding duty to warn of medical risks

The notion of professional advice

Professional advice, though part of professional practice, can be separated from the latter. Typical examples would include the advice of an architect regarding a building to be erected by a builder or the advice provided by a solicitor to a client, who agrees to the matter being handed over to the barrister. The barrister's advice may or may not trigger the process of litigation. Financial advice can be separated from the undertaking of investment, and medical advice from treatment or invasive examination. In each instance, the separating factor is the conduct of the plaintiff who, having received the advice, makes a choice whether or not to act on it.

Yet, in Canterbury v Spence and Rogers v Whitaker, when imposing liability for negligent duty to advise of risks inherent in a proposed medical treatment, the judges embraced the view that advice constitutes an element of a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment". This sweeping definition of duty not only is at odds with the classical understanding of what constitutes medical treatment, but also confuses legal interests involved in the advice and treatment.

Since the advent of Hippocratic medicine, medical treatment has been understood to be comprised of three components: diagnosis, prognosis and therapy. This understanding has been reflected in the tort of negligence, which traditionally imposed upon medical practitioners the duty to exercise reasonable care and skill in the examination, diagnosis and treatment of the patient. Advice about risks that would enable patients to decide freely whether or not to consent to invasive examination and therapy was, and is, safeguarded by the tort of trespass to the person.

Common law jurisprudence thus distinguishes legal interests protected by trespass to the person from legal interests protected by the law of negligence. The right to give or to refuse consent, protected by the tort of trespass to the person, involves two legal interests – the interest in one's physical integrity as well as the dignitary interest in autonomy and personal self-determination. Lord Donaldson MR distinguished the interests protected by the requirement of consent to treatment from interests involved in the right to competent therapy, when he stated that "consent by itself creates no obligation to treat". Rather, consent operates like a "legal 'flak jacket' which protects the doctor from claims by the litigious". In other words, consent is preliminary to and separate from examination and treatment, the standards of which are governed by
the law of negligence. This substantive distinction between rights and interests protected by the tort of trespass to the person on the one hand, and negligence on the other, was blurred when the courts imposed upon medical practitioners an affirmative duty to disclose risks inherent in the proposed treatment.

Thus in *Rogers v Whitaker* a medical practitioner failed to advise his patient about remote but serious risks inherent in an eye operation. The operation was performed with the required skill, but the patient was rendered blind. Likewise, according to the majority in *Chappel v Hart*, the surgeon, having advised the patient about the more common complications that were inherent in the proposed procedure, failed to inform her about the risk of further complications that had the potential randomly to follow. Again, a sequence of complications, which until then were considered possible but unlikely, resulted in a paralysis of a laryngeal nerve. In *Rosenberg v Percival*, the defendant surgeon, Mr Rosenberg, relying on a pre-operative radiological examination and a radiology report, which stated that the patient's temporomandibular joints were normal, did not discuss with her possible adverse consequences of the sagittal split osteotomy on these joints. The temporomandibular joints disorder "triggered off" by the surgery was painful and debilitating.

In all three cases, the respective trial judges found that adverse consequences had occurred despite the surgery having been performed with competence and skill. Consequently, the question of liability turned on whether the defendant surgeons breached their duty to disclose inherent risks of the proposed procedure. The judiciary stated that the imposition of such duty would enable patients to exercise their right of choice whether or not to consent to the proposed treatment. For example, according to Kirby J in *Rosenberg v Percival*:

> Fundamental to the formulation [of duty to warn of inherent risks] adopted by this Court in *Rogers* is a recognition, expressed much earlier in the United States cases, that a patient "has a right to determine what shall be done with his own body".

However, it is difficult to make jurisprudential sense of the explanations why the legal interest in the right to choose or decline medical treatment should be safeguarded through the general law of negligence under the *Donoghue v Stevenson* cause of action (which the author calls "negligence simplex"), in the form of an affirmative duty to disclose.

To deal with this problem, the court in *Canterbury v Spence* developed the doctrine of "informed consent" to justify the imposition of an affirmative duty to disclose medical risks on the grounds that the "patient's right to self-decision shapes the boundaries of the duty to reveal". Therefore, the patient's interest in bodily integrity commands "protection, not only against an intentional invasion by an unauthorised operation but also against a negligent invasion by his physician's dereliction of duty to adequately disclose".

(2001) 8 JLM 358 at 361

The reasoning is muddled for, strictly speaking, "negligent invasion", just like any other "invasion", should sound in trespass to the person rather than negligence. Indeed, in *Rogers v Whitaker*, the High Court followed the Canadian Supreme Court in *Reibl v Hughes* and the House of Lords in *Sidaway v Governors of Bethlem Royal Hospital*, when it rejected the doctrine of informed consent in the context of the law
of negligence. The court described the phrase "informed consent" as "somewhat amorphous", and "apt to mislead as it suggests a test of the validity of a patient's consent". It also noted that the expression "the patient's right to self-determination" is:

perhaps, suitable to cases where the issue is whether a person has agreed to the general surgical procedure or treatment, but is of little assistance in the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure.

Instead, the High Court explicitly adopted the approach of King CJ who, in \textit{F v R}, discussed the issue of the imposition of the new duty of disclosure in terms of two conflicting values – the duty of doctors to act in what they conceive to be the best interests of the patient, and the right of the patient "to control his own life and to have the information necessary to do so". King CJ determined that the second right should prevail. The High Court justified the imposition of an affirmative duty to disclose on the grounds that "except in cases of emergency or necessity, all medical treatment is preceded by the patient's choice to undergo it", and that the "choice is, in reality, meaningless unless it is made on the basis of relevant information and advice".

These statements imply that the tort of trespass protects patients' freedom of choice through the right to decide whether or not to consent to an interference, whereas the tort of negligence protects patients' right to be informed about the factors which will be material to that decision.

In principle, there is no jurisprudential barrier to two different torts safeguarding the same legal interest. However, the interest in freedom from invasion of pure personal autonomy has been outside of the purview of negligence, which – as a matter of principle – has protected only interests in actual physical, proprietary and psychological integrity (freedom from negligently inflicted psychiatric injury). Moreover, the damage occasioned by the defendant's wrongful conduct in cases of negligent failure to advise about risks is not of the kind usually protected by negligence simplex.

\textbf{Consequential damage}

Apart from special duty situations, which nowadays tend to form distinct categories of case, to be compensable in negligence simplex the plaintiff's damage must be of a primary kind – it must arise as a result of the defendant's wrongful conduct rather than being mediated through an independent agency. Conceptually, damage claimed in negligent failure to disclose medical risks is not primary but consequential, in the sense of being "one step removed" from the alleged wrongful conduct. In \textit{San Sebastian v Minister Administering the Environmental Planning and Assessment Act 1979}, the High Court noted that in negligent representation cases: damage flows, not immediately from the defendant's act in making a statement but from the plaintiff's reliance on the statement and his action or inaction which produces consequential loss.
When plaintiffs allege that the medical practitioner failed to disclose a particular risk inherent in a proposed procedure, their primary damage is in the form of a "meaningless decision," but the tort of negligence does not provide remedies for this kind of dignitary harm. The physical harm that they suffer is an unintended consequence of a skilfully performed procedure. In other words, the actionable damage flows from a non-negligent act. However, by a fiat of jurisprudential magic, the courts have conflated the two kinds of harm, attributing the physical harm to the inadequate disclosure. By rejecting the informed consent doctrine as the foundation of the medical duty to disclose, on the one hand, and by failing to provide an alternative legal principle for the imposition of this novel duty, on the other, the High Court has created an epistemological conundrum.

The concept of negligent representation or non-disclosure occasioning consequential damage was first canvassed as a separate category of case by the House of Lords in *Hedley Byrne v Heller & Partners*. Duties, including the duty to disclose, that are additional or "special" to the tort of negligence simplex were imposed on the basis of the particular nature of the relationship between the parties. To attract the affirmative duty to disclose, the representee had to show that in seeking the information upon a serious matter from the representor, the representor was trusted to exercise due care, and that he or she knew or ought to have known that reliance was being placed on competent exercise of skill and judgment. A professional relationships between doctor and patient would fall within the above definition, and thus give rise to an affirmative duty to provide adequate and careful information about medical risks. Damage in the form of negligent or reckless infringement of the right to adequate advice would probably make the new cause of action more akin to trespass than negligence, but this would be to the advantage of the plaintiff.

The *Hedley Byrne* case could have provided a foundation for an obligation to disclose risks inherent in a proposed course of action in the context of professional relationships. However, as is the wont of the common law, it so happened that, in that case, the plaintiff claimed damages for both negligent advice and pure economic loss. This meant that the court had to consider the inherent potential of words uttered negligently to cause financial damage that was difficult to foresee with any degree of precision. Their Lordships proceeded on the assumption that a claim for pure economic loss was not very different from one for consequential physical damage. The substantive difference lay in the source of this loss, namely, negligent representation or non-disclosure rather than physical conduct. The emphasis on the negligent acts and words as the source of liability is in harmony with the principle that the major concern of the law of torts is wrongful conduct rather than the nature of the damage resulting from it. Nevertheless, the convergence of negligent advice with pure economic loss in *Hedley Byrne*, and in subsequent cases, has created the perception that this category of case has two features: negligent representation and pure economic loss, with the emphasis on the latter.

Yet, if we were to refocus on the issue of conduct rather than damage, there is no jurisprudential barrier to providing compensation to plaintiffs whose right to make autonomous choices is impaired as a result of negligent professional advice. The question that will have to be resolved is

*(2001) 8 JLM 358 at 363*
the valuation of this kind of negligent denial of the right to autonomy.

**Causation**

As noted above, in *Rogers v Whitaker* the High Court stated that medical practitioners are under a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment".\(^{48}\) The phrase "covering all ways" allows the court to exercise unbridled discretion when deciding on the required normative standard of care pertaining to the doctor's "exercise of skill and judgment".\(^{49}\)

More importantly, no matter how laudable the rhetoric that underlies the *Rogers v Whitaker* duty to warn, it cannot overcome problems of causation, which, at least initially, is a question of fact. Thus, according to Gummow J in *Rosenberg v Percival*:

> [T]here must be a causal connection, in the legal sense, between the failure to warn of the material risk and the occurrence of the injury. Cases involving a failure to warn of a risk encounter difficulties of causation that do not arise in cases of, for example, a negligent physical act "causing" injury. The failure to warn the patient of the risk can never amount in the same sense to the cause of the injury. Moreover, the issue of failure to warn usually arises when the performance of the physical cause of the injury was not negligent.\(^{50}\)

While pinpointing the problem, neither his Honour nor the rest of the court in *Rosenberg* provided a satisfactory solution to it. Mesmerised by the notion of a "single comprehensive duty", the court has failed to analyse what would happen in cases where the damage is the same, but the advice is split from the performance of the procedure. In other words, what if Mrs Whitaker, Mrs Hart or Dr Percival received the inadequate advice from respectively Mr Rogers, Mr Chappel or Mr Rosenberg, but the respective procedures were competently performed by different surgeons, though with the same adverse sequelae?

Had this question been asked, the court would have had to acknowledge that the foreseeable risk created by the defendant's wrongful non-disclosure is different from foreseeable risks created by careless or incompetent performance of the treatment. Assuming that a correct diagnosis has been made, if a doctor then negligently fails to disclose a serious risk inherent in the treatment, but the patient, for reasons of her own, does not go ahead with the treatment, the negligent conduct will not be actionable. This is because the risk of non-disclosure merely relates to the denial of the plaintiff's right to make "meaningful choices" regarding treatment options. As much was acknowledged by Gummow J in *Rosenberg v Percival* who, while discussing the nature and "materiality of risk" that needs to be disclosed under the *Rogers v Whitaker* duty, stated:

> Where the action is brought in negligence and the plaintiff is seeking compensation for an injury suffered, the relevant risk is the possibility that the proposed treatment will result in the injury that in fact occurred. It is not, for example, the risk that the patient will make an uninformed decision or choose the wrong option, although that may well underpin the rationale behind the duty.\(^{51}\)

Epistemological perplexities inherent in this approach can be illustrated through a non-medical example. A skier intending to ski on the slopes of Porter Heights in New
Zealand rings the Bureau of Meteorology, informs the meteorologist on duty of his intentions, and asks how safe it is to ski in the particular area. He is told that conditions are clear, and that there have been no recorded avalanches in this area. An unexpected avalanche develops and injures the skier. Should the meteorologist be liable for failure to warn about the possibility of the risk of an avalanche occurring? If so, can the

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meteorologist successfully plead vis major? But then, what is the conceptual difference between known but unexpected and unpredictable events happening in the mountains and equally unpredictable reactions of the human body? Does the difference lie in the myth that, just as we know how the computer works and thus have mastery over it, we know or ought to know and master how the human "mechanism" works, a claim we do not make for nature at large.

Having to focus on the ultimate physical damage in medical negligence cases means that the concept of fault is stretched to cover not only negligent words but also blameless physical conduct. Consequently, the judiciary has created a legal oddity whereby surgeons who both advise and operate on a patient can be held liable. However, a patient who, as a result of inadequate advice by one surgeon, had agreed to undergo an operation by another, and suffered an adverse outcome from a competently performed procedure would be unable to successfully sue the performing surgeon in negligence. At the same time, it would be difficult to prove that the advising surgeon's failure to warn of an unlikely but possible risk had caused the patient's actual physical injury.

A discrete remedy for failure to advise of risks may also alleviate other substantive problems of causation, which remained unresolved in *Chappel v Hart* and were only partially tackled in *Rosenberg v Percival*. According to the High Court, the function of causation in negligence is to attribute the fault or legal responsibility to the "identified negligent act or omission of the defendant" on the basis that it "was so connected with the plaintiff's loss or injury that, as a matter of ordinary common sense and experience, it should be regarded as a cause of it". The requisite connection will be established if the negligent conduct caused or materially contributed to the injury. As pointed out above, in *Chappel v Hart* the majority regarded the surgeon's fault in the form of failure to advise about the risk as having caused or materially contributed to the plaintiff's injury in the form of laryngeal paralysis. Far from applying common sense and experience, it takes a leap of logic as well as imagination to accept this conclusion.

In *Bennett v Minister of Community Welfare*, the joint judgment left unanswered the question whether "a failure to take steps which would bring about a material reduction of the risk amounts to a material contribution to the injury". In *Chappel v Hart*, the majority asked whether the failure to advise of risks amounted to a material contribution to the injury, which is different from the Bennett question, namely, whether advising Mrs Hart about the risk to her laryngeal nerve would have brought about a material reduction of that risk.
If the question were cast in this way in *Chappel v Hart*, one would have had to consider the fact that, unlike Mrs Whitaker whose eye operation was essentially cosmetic, Mrs Hart would have had to undergo the procedure sooner rather than later even if there was no failure to inform her that the operation involved an inherent risk of mediastinitis injury to the laryngeal nerve.

The question arises why, given the randomness in the incidence of oesophageal perforations together with the constant presence of bacteria in the gastric system, but its random spread into the oesophagus, the plaintiff's knowledge of the risk should have brought a material reduction of the risk created by the convergence of these factors. The prediction that the risk would not have eventuated if there were a postponement of the operation is speculative, yet this determination was pivotal to the outcome of the case. If the law is to be credible, the discourse about the breach of duty to advise about risks should be distinguished from the discourse about the causes of a plaintiff's physical injury. As Hayne J in his dissenting judgment in *Chappel* pointed out:

The difficulty in the analysis that looks only to whether the subject matter of the negligent conduct (failure to warn of risk to voice) and the damage suffered (damage to the voice) are the same is that it does not pay sufficient heed to the comparison that the law requires between the facts of what happened and the hypothetical facts of what would have happened if there had been no negligent act or omission.

In a cause of action for failure to advise of risks inherent in the proposed course of action causation would not be in issue, for there would be a presumption that, unless disproved, the defendant's fault resulted in the denial of the plaintiff's right to an informed decision-making. This being an actionable damage, the question whether its value should sound in nominal or substantive damages would be determined by reference to policy considerations.

**Hindsight bias**

In Australia, in cases where failure to warn is in issue, causation has to be established by the subjective test of whether the particular patient-plaintiff's state of mind was such that, if told of the risk, he or she would have refused to undergo the procedure. Naturally, such plaintiffs argue that, had they known about the risk of the post-operative complications they suffered, they would never have agreed to the procedure. Gleeson CJ in *Rosenberg v Percival* had thus identified the evidentiary problem raised by the subjective test of causation:

In the way in which litigation proceeds, the conduct of the parties is seen through the prism of hindsight. A foreseeable risk has eventuated, and harm has resulted. The particular risk becomes the focus of attention. But at the time of the allegedly tortious conduct, there may have been no reason to single it out from a number of adverse contingencies, or to attach to it the significance it later assumed. Recent judgments in this Court have drawn attention to the
danger of a failure, after the event, to take account of the context, before or at the time of the event, in which a contingency was to be evaluated.62

The issue of "hindsight bias" was addressed by each of the judges in *Rosenberg v Percival*.63 Hindsight bias refers to a psychological phenomenon whereby people, while retrospectively considering the occurrence of a past event, "tend to exaggerate the extent to which it could have been correctly predicted beforehand".64 In hindsight, once the undisclosed risk has materialised, medical practitioners appear negligent, even if in foresight that would not have been the case, and likewise the plaintiffs – having experienced the adverse outcome – are predisposed to believe that they would not have agreed to the procedure.65 Factoring in the hindsight bias is particularly important where liability is determined on the basis of what was said rather than what was done. For when people examine past decisions they are inclined "to highlight data that were consistent with the final outcome and de-emphasise data that were contradictory or ambiguous".66

In *Rosenberg*, the hindsight bias was discussed solely in relation to the plaintiffs' credibility as

(2001) 8 JLM 358 at 366

witnesses when they assert that, if warned of the risk, they would not have proceeded with the surgery. While upholding the discretion of the trial judge to believe or disbelieve the plaintiff's claim, the court67 suggested a number of objective factors that have a role in the assessment of the plaintiff's state of mind at the time of electing whether to have the procedure. In determining the issue of credibility,68 the trial judge would be expected to consider the plaintiff's personality and demeanour; the need for the procedure as established by the medical history and medical opinion; the nature of the risk inherent in the procedure and its likelihood of materialising; the plaintiff's professional background; his or her knowledge of treatment options; the level of questioning or failure to ask about the specific risk; and willingness to undergo the general risks of the procedure (for example, a general anaesthetic). These detailed guidelines go some way towards reducing the hindsight bias; however, separating consequential physical or economic outcome from the breach of duty to advise, would minimise the bias even further.

**Conclusion**

Writing in defence of the *Rogers v Whitaker* doctrine, Kirby J in *Rosenberg* stated:

Fundamentally, the rule is a recognition of individual autonomy that is to be viewed in the wider context of an emerging appreciation of basic human rights and human dignity. There is no reason to diminish the law's insistence, to the greatest extent possible, upon prior, informed agreement to invasive treatment, save for that which is required in an emergency or otherwise out of necessity.69

The problem is that the negligence action created to protect the rights articulated by Kirby J is fundamentally flawed. Locating liability for negligent medical advice in the category of case for breach of professional obligation to disclose risks would have two jurisprudential advantages. First, the concept of duty to disclose based on respect of individual autonomy fits in logically with the notion of careful representation in
circumstances where there exists a professional undertaking to inform on the part of the defendant, and a reasonable reliance on the part of the plaintiff that the information will be correct and comprehensive. Secondly, such a remedy would provide a clear conceptual nexus between the claimant's right to disclosure of the risk and the infringement of that right through non-disclosure or inadequate disclosure.

One of the virtues of the common law system is its ability to modify flawed or iniquitous doctrines. Historically, the High Court of Australia has been willing to incorporate existing causes of action into other torts, thus altering the elements of the former remedy. For example, in 1994, the strict liability of an occupier of land in respect of injury caused by the escape of a dangerous substance involved in the non-natural use of land under the tort of *Rylands v Fletcher* was incorporated into the dominion of "ordinary negligence", or, in particular circumstances, into nuisance and trespass. Likewise, the general action on the case against government officials, which provided a remedy for plaintiffs who could prove that they suffered damage as an inevitable consequence of the unlawful, intentional and positive acts of government officials, was absorbed into the law of negligence. More recently, the High Court established a new duty of care, when it held that the rule in *Cavalier v Pope*, under which landlords were not liable for injuries that arose from the defective state of land or premises let in a dangerous or dilapidated condition, should no longer be followed in Australia.

When determining the jurisprudential question of whether a particular cause of action should be followed in its extant form, the High Court of Australia tends to consider not only the status of authorities that support it, but also whether the specific requirements of the action are in harmony with general principles that underpin the law of tortious liability. As has been explained above, at present it is difficult to reconcile the liability for medical failure to disclose with principles of duty, breach and causation under the *Donoghue v Stevenson* cause of action.

Discussing jurisprudential foundations for judicially formulated principles in civil cases, Dworkin, in his seminal book *Taking Rights Seriously*, distinguished principles, which are propositions that describe rights, from policies, which are propositions that describe goals. According to Dworkin, in the context of legal standards that guide the judicial decision-making process, policies set out collective community goals such as the advancement or protection of political aims, economic efficiency or social welfare. Principles are to be observed because they embody the requirements of justice or fairness or some other dimension of morality which respects or secures some individual or group right. Dworkin contended that, in civil cases, judicial determinations characteristically are, and should be, generated by principle not policy; and that adjudication of what legal rights people have should be made in the light of an overall political theory which recognises moral-political background rights (rights that provide a justification for a political decision by the society) as well as those concrete rights against fellow citizens already demarcated by enactments. A professional obligation to disclose risks inherent in the proposed course of action would sit well with the notion that in modern Australian society, the law should recognise the legal interest in the right to adequate information for those
who seek professional advice. At the same time, the law should also protect those who provide the information from being held liable for pure coincidences.

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1 464 F 2d 772 (DC Cir 1972).

2 (1992) 175 CLR 479. The defendant ophthalmic surgeon performed an essentially cosmetic operation on the plaintiff's right eye. The plaintiff was apparently nervous and "keenly interested" to know of possible complications which might attend the operation. The surgeon failed to disclose the possibility of a risk (1 in 14,000) of sympathetic ophthalmia occurring in her left eye. Although the operation was carried out without negligence, the sympathetic ophthalmia developed and the plaintiff became virtually blind.

3 (1998) 195 CLR 232. The plaintiff had a wide-necked pharyngeal diverticulum (pharyngeal pouch) which, when inflamed, was very distressing. The defendant surgeon, who advised her that the pharyngeal pouch should be surgically removed, provided information about the risk of oesophageal perforation, but failed to mention the risk of mediastinitis, which may lead to a number of further complications. These included inflammation of laryngeal nerves, which may, on rare occasions, cause a loss of function in a vocal cord. The operation was performed competently, but subsequent mediastinitis resulted in temporary paralysis of the plaintiff's laryngeal nerve.

4 [2001] HCA 18. Having considered three different treatment options for correction of severe malocclusion due to underdeveloped jaw, the plaintiff, Dr Percival, underwent an elective bilateral sagittal split osteotomy. Post-operatively, the patient developed a painful temporomandibular joint disorder, which was not alleviated by subsequent manipulation of the temporomandibular joints. The plaintiff was not warned of the inherent risk of temporomandibular disorders, and claimed that, had she been alerted to this risk, she would not have consented to undergo the procedures. The High Court upheld the trial judge's finding that the plaintiff failed to prove this claim, and with it the requirement of causation.

5 [1932] AC 562.

6 See R K Fullinwider, "Professional Codes and Moral Understanding" in M Coady and S Bloch (eds), Codes of Ethics and the Professions (Melbourne University Press, Melbourne, 1996), p 73.

7 (1992) 176 CLR 408.

8 The defendant was held liable for the failure to obtain independent advice, which deprived the plaintiff of an opportunity to bring a timely claim for damages.

9 Hawkins v Clayton (1988) 164 CLR 539 and Hill v van Erp (1997) 188 CLR 159 involved failure by solicitors to provide correct advice. The cases are different from the medical cases under discussion, because in Hawkins the breach of duty consisted of
failure to provide any representation on the matter, and in Hill the advice was incorrect rather than incomplete.

10 Breen v Williams (1996) 186 CLR 71.


13 Rogers v Whitaker (1992) 175 CLR 479 at 487.

14 Re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1992] 3 WLR 758 at 765.


17 Re W (A Minor) (Medical Treatment: Court's Jurisdiction) [1992] 3 WLR 758 at 767.

18 (1992) 175 CLR 479.

19 Rosenberg v Percival [2001] HCA 18 at [71] per Gummow J, at [171] per Callinan J. The patient informed the defendant that she experienced muscle ache along the jawline, but he considered that it was due to a minor disorder. Having read the radiology report, Dr Percival did not ask any questions with regard to it.

20 The possibility of temporomandibular disorders following an osteotomy was known, but experts were divided in their opinion on the degree of remoteness of the contingency, and the need to warn about it: Rosenberg v Percival [2001] HCA 18 at [15] per Gleeson CJ; at [70] per Gummow J.


22 Rogers v Whitaker (1992) 175 CLR 479 at 490.

23 Schloendorff v Society of New York Hospital 105 NE 92 at 93 (1914): "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."

24 Rosenberg v Percival [2001] HCA 18 at [142]. Kirby J at [140] also stated: "In Rogers this Court did not explain the duty to warn in terms of 'informed consent', because it was there concerned with a cause of action framed in negligence, not trespass. 'Consent' (or the lack of it) was not, as such, a defence. Nevertheless, there is no doubt that the rule that the Court expressed in Rogers was addressed to the concerns that are commonly dealt with, in legal and medical literature, as
relevant to securing the 'informed consent' of a patient to invasive treatment."

26 464 F 2d 772 (DC Cir 1972). The case involved a young man who complained of pain in the back. He submitted to an operation without being informed of a risk of paralysis incidental thereto. A day after the operation he fell from his hospital bed after having been left without assistance. A few hours after the fall, the lower half of his body was paralysed, and he had to be operated on again, without success.
27 Ibid at 786.
28 Ibid at 793.
30 [1985] AC 871.
31 Rogers v Whitaker (1992) 175 CLR 479 at 490.
32 Ibid.
34 Ibid at 191.
35 Rogers v Whitaker (1992) 175 CLR 479 at 490.
36 Ibid.
37 The overlapping of remedies may occur in private nuisance and negligence (Overseas Tankship (UK) Ltd v The Miller Steamship Co Ltd (The Wagon Mound (No 2)) [1967] 1 AC 617); battery and negligence (Gray v Motor Accident Commission (1998) 73 ALJR 45); conversion and trespass to goods (Penfolds Wines Pty Ltd v Elliott (1946) 74 CLR 204).
38 For example, liability for pure omissions (nonfeasance) (Sutherland Shire Council v Heyman (1985) 157 CLR 424); liability for pure psychiatric injury (Jaensch v Coffey (1983) 155 CLR 549); liability for pure economic loss (Perre v Apand Pty Ltd (1999) 198 CLR 180); and non-delegable duty of care (Burnie Port Authority v General Jones Pty Ltd (1994) 179 CLR 520).
39 Cf P Cane, "The Blight of Economic Loss: Is There Life After Perre v Apand?" (2000) TLJ 1 at 10: Hedley Byrne and MLC are examples of direct economic loss. A person suffers relational economic loss when their economic loss is consequential upon loss (whether physical or economic) suffered by someone else as a result of the defendant's negligence.
40 (1986) 162 CLR 341. The case concerned property developers who purchased large parcels of land in reliance on a "green paper" redevelopment study and proposals.
41 Ibid at 353.
42 Rogers v Whitaker (1992) 175 CLR 479 at 490.
to another upon a serious matter in circumstances where the speaker realises, or ought to realise, that he is being trusted to give the best of his information or advice as a basis for action on the part of the other party and it is reasonable in the circumstances for the other party to act on that information or advice, the speaker comes under a duty to exercise reasonable care in the provision of the information or advice he chooses to give."

45 Hill v Van Erp (1997) 188 CLR 159.
47 Hedley Byrne v Heller & Partners [1964] AC 465. The plaintiff, anxious to know whether it could safely extend credit to a client company, asked its own bank to approach the defendants, Heller & Partners, to assess the viability of a client company. The defendants gave a gratuitous reference, which was so carelessly phrased that it led the plaintiff to believe that the client company was credit-worthy, when in fact it was not. Despite a disclaimer attached to the reference, the plaintiff extended credit to the company and suffered loss when the company went into liquidation.


49 In Rosenberg v Percival, the High Court was divided on the issue of breach through failure to warn of the risk of temporomandibular disorders. Gleeson CJ and Gummow J agreed with the trial judge that the defendant surgeon did not breach his duty of care, because he was not under a duty to warn the patient of the particular risk. McHugh J did not determine the issue of breach; Callinan J, while doubtful that the injury presented a "material risk" and that failure to warn about it amounted to a breach of duty of care, did not express final opinion on this issue. Kirby J found that the surgeon was in breach of duty to warn. For the critique of the Rogers v Whitaker standard see Rosenberg v Percival [2001] HCA 18 at [14] per Gleeson CJ. For a discussion of "material risk" in the context of medical duty to warn, see ibid at [61]-[69] per Gummow J; at [214]-[216] per Callinan J.

50 Ibid at [84] per Gummow J.
51 Ibid at [61].
52 Causation was not discussed in Rogers v Whitaker, but it was the determining issue in Chappel v Hart.

53 In Rosenberg v Percival all judges agreed that even if Dr Percival had been made aware of the risk, she would have decided to undergo the surgery.


55 Bonnington Castings Ltd v Wardlan [1956] AC 613 at 621.
56 (1992) 176 CLR 408 at 416. The court also noted that in cases of advice where the issue relates to whether the failure constituted supervening or concurrent cause, "it might be necessary to consider the view that there is no real distinction between breach of duty and
causation". The reference was made to McGhee v National Coal Board [1973] 1 WLR 1 at 8 per Lord Simon of Glaisdale; Quigley v Commonwealth (1981) 55 ALJR 579 at 581 per Stephen J. See also TC v New South Wales [2000] NSWSC 292 per Studdert J.

57 Rosenberg v Percival, [2001] HCA 18 at [97] per Gummow J.


59 Chappel v Hart (1998) 195 CLR 232 at 286 per Hayne J.

60 McHugh J in Rosenberg v Percival [2001] HCA 18 at [45] distinguished between the patient's state of mind upon receiving the advice and his or her subsequent actions: "In terms of causation theory, the critical fact is whether the patient would have taken action – refusing to have the operation – that would have avoided the harm suffered. But that fact can only be determined by making an anterior finding as to what the patient would have decided to do, if given the relevant warning. It is not possible to find what the patient would have done without deciding, expressly or by necessary implication, what decision the patient would have made, if the proper warning had been given. If the court finds that the patient would have decided not to have the operation, it concludes that he or she would not have had the operation. What the patient would have decided and what the patient would have done are hypothetical questions. But one relates to a hypothetical mental state and the other to a hypothetical course of action."

61 Ibid at [24] and [44] per McHugh J; at [153]-[154] per Kirby J.

62 Ibid at [16].

63 Ibid at [16] per Gleeson CJ; at [26] per McHugh J; at [68] per Gummow J; at [156] per Kirby J; at [214], [219] per Callinan J.,


65 For discussion of studies on "hindsight bias" see Arkes and Schipiani, op cit n 64, at 588-589. Judges, too, can reason by hindsight; eg, in Chappel v Hart (1998) 195 CLR 232 at 239, Gaudron J said: "If that evidence is to the effect that the injured person would have acted to avoid or minimise the risk of injury, it is to apply sophistry rather than common sense to say that, although the risk of physical injury which came about called the duty of care into existence, breach of that duty did not cause or contribute to that injury, but simply resulted in the loss of an opportunity to pursue a different course of action" (emphasis added).


68 Ibid at [30]. McHugh J noted that the assessment of the witness's
credibility should not be influenced by determining the cause or causes of the lack of credibility, be they psychological or physical consequences of the unfortunate event or the desire to win the case.

69 Ibid at [145].

70 Even very famous legal doctrines do not escape modifications. Thus, within a decade of the House of Lords decision in Donoghue v Stevenson, the concept of "neighbour in law" for the purposes of the test of reasonable foreseeability was modified (not always for the better) in Chester v Waverley Corp (1939) 62 CLR 1; Levi v Colgate-Palmolive Pty Ltd (1941) 41 SR (NSW) 48; Bourhill v Young [1943] AC 92.

71 Burnie Port Authority v General Jones Pty Ltd (1994) 179 CLR 520. In the same case, the High Court held that the ignis suus principle relating to the liability of occupiers for damage caused by the escape of fire from their premises was no longer applicable to provide protection for liability which arises under the general principles of negligence.

72 Ibid at 556 per Mason CJ, Deane, Dawson, Toohey and Gaudron JJ.


75 Northern Sandblasting Pty Ltd v Harris (1997) 188 CLR 313.

76 [1906] AC 428.

77 Unless the landlord acted fraudulently, or an express term of contract prohibited a lease of dangerous premises.


80 Ibid.


82 Ibid, p 90.

83 Ibid, pp 82, 22.


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