

Rogers v whtaker | analysis



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Brief Statement Of The Facts

The patient, Ms Whitaker, decided to have elective surgery on her right eye, which was vision-impaired from an accident which had occurred in her youth.

1 Despite the almost total blindness resulting in the right eye, she had led a “substantially normal life”, working, marrying and raising children. However on having a check-up, surgery was recommended on the basis that she could benefit, even cosmetically. 2 Subsequent to surgery complications developed in the right eye, spreading to the left eye and resulting in almost total blindness. This is known as “sympathetic ophthalmia”, and is a recognized risk of eye surgery. 3 At no stage was Ms Whitaker warned of the probability of this occurring. Ms Whitaker sued in negligence on several grounds, including failure of Dr Rogers to warn her of the risk of sympathetic ophthalmia, performing an ill-advised operation, failure to follow up missed appointments, failure to enucleate the right eye following development of symptoms of sympathetic ophthalmia in the left eye. 4

... Ms Whitaker had expressed a keen interest in avoiding harm to her good eye, and Dr Rogers was aware of this;

... she repeatedly asked about the risks;

... Dr Rogers was aware at the time of the risk, although it was remote; the failure to warn of the risk was not contemplated for therapeutic reasons; and

... had Ms Whitaker been advised of the risk, she would not have had the surgery.

Issues

The defence relied on the principle enunciated in Bolam v Friern Hospital Management Committee. 6 That case ruled that the decision of what to tell a person is one which the doctor can make based on medical judgment. That would make a doctor not negligent if he or she acts in accordance with a practice of disclosure or non-disclosure accepted at the time as proper practice by a responsible body of medical opinion, even if some doctors adopt a different practice. 7 The defence tendered evidence from a group of specialists who supported Dr Roger's actions. The defence further relied on the fact that the risk of sympathetic ophthalmia was considered to be 1 in 14, 000, and therefore too remote to mention to the patient. 8 The judge in the trial rejected all but the first ground of complaint, and ruled that the failure to warn of the risk of sympathetic ophthalmia amounted to negligence.

D. A. Wheelahan Q. C., for the respondent said that the standard of care required of medical practitioners is to be determined in accordance with the test that applies to all other tortfeasors. 10 Bolam v Friern Hospital Management Committee does not establish that simply because there is a body of reasonable medical opinion, that a practitioner who follows that opinion cannot be guilty of negligence. 11 The patient in Bolam v Friern Hospital Management Committee did not ask any questions. The desire of the patient to know about the operation and its risks requires the provision of information that might not otherwise be required. 12 The surgery was elective. There was no medical urgency. Therapeutic privilege did not justify withholding information. In those circumstances the respondent should have

been warned of the risk to her good eye. It is the patient's decision whether to have an operation. The practitioner cannot know what matters might be relevant to the patient's decision. Whatever the position in England, the law in Australia requires a practitioner to disclose any real risk of misfortune inherent in an operation and also any real risk that an operation may prove ineffective.

The appeal first went to the New South Wales Court of Appeal where it was dismissed, and then to the High Court of Australia. The High Court said that the principle in *Bolam*¹⁴ is no longer applicable in determining whether a medical practitioner has given adequate information about a medical procedure to a patient. Instead the Court followed the judgment in *F v R*¹⁵ where it was assured that even though the court will judge proof by medical specialists of what is believed appropriate medical practice, it is eventually the area of the court to decide what the suitable criterion of care is, and that the principal deliberation is to be that a person is allowed to make his or her own assessments about his or her life. ¹⁶ The court further declared that the more radical the planned process, for instance major surgery, the more essential it is to keep the patient up to date about the risks.

The High Court drew a distinction between diagnosis and treatment on the one hand, and provision of information, on the other. The former was held to be determined by the medical practitioner, whereas the provision of adequate information is a right of the patient. ¹⁷ Medical information is a right. This right is not based on medical judgment, but on legal principles, and it is for the court to decide whether a person's right to be adequately informed about a procedure, has been breached or not. This may be based

on consideration of medical practitioners, as what is considered appropriate practice, but in the final analysis it will be a matter for the court to determine, given the paramount consideration that people are entitled to make their own decisions about their own lives.

Judicial Reasoning

Negligence – Breach of duty – Medical practitioner – Duty to warn of possibility of adverse effect of proposed treatment – Extent of duty.

Mason C. J., Brennan, Dawson, Toohey and McHugh JJ on Breach of Duty and Causation stated that the evidence established that there was a body of opinion in the medical profession at the time which considered that an inquiry should only have elicited a reply dealing with sympathetic ophthalmia if specifically directed to the possibility of the left eye being affected by the operation on the right eye. While their opinion that the respondent should have been told of the dangers of sympathetic ophthalmia only if she had been sufficiently learned to ask the precise question seems curious, it was unnecessary for them to examine it further, save to say that it demonstrates vividly the dangers of applying the Bolam principle in the area of advice and information.

The respondent may not have asked the right question, yet she made clear her great concern that no injury should befall her one good eye. The trial judge was not satisfied that, if the respondent had expressed no desire for information, proper practice required that the respondent be warned of the relevant risk. But it could be argued, within the terms of the relevant principle, that the risk was material, in the sense that a reasonable person in

the patient's position would be likely to attach significance to the risk, and thus required a warning. It would be reasonable for a person with one good eye to be concerned about the possibility of injury to it from a procedure which was elective. However, the respondent did not challenge on appeal that particular finding. For these reasons, the judges rejected the appellant's argument on the issue of breach of duty. On Causation, although the appellant's notice of appeal challenges the confirmation by the Court of Appeal of the trial judge's finding that the respondent would not have undergone the surgery had she been advised of the risk of sympathetic ophthalmia, counsel for the appellant made no submissions in support of it. There was, therefore, no occasion to deal with this ground of appeal. For the foregoing reasons, the Judges dismissed the appeal.

Gaudron J. stated that the facts and the issues were set out in the joint judgment of Mason C. J., Brennan, Dawson, Toohey and McHugh JJ. Save for the following comments, he agreed with the reasons set out in that judgment and he agreed with their Honours' conclusion that the appeal should be dismissed.

There was no difficulty in analyzing the duty of care of medical practitioners on the basis of a "single comprehensive duty" covering diagnosis, treatment and the provision of information and advice, provided that it is stated in terms of sufficient generality. Thus, the general duty may be stated as a duty to exercise reasonable professional skill and judgment. But the difficulty with that approach is that a statement of that kind says practically nothing – certainly, nothing worthwhile – as to the content of the duty. And it fails to take account of the considerable conceptual and practical differences

between diagnosis and treatment, on the one hand, and the provision of information and advice, on the other.

The duty involved in diagnosis and treatment is to exercise the ordinary skill of a doctor practising in the area concerned. To ascertain the precise content of this duty in any particular case it is necessary to determine, amongst other issues, what, in the circumstances, constitutes reasonable care and what constitutes ordinary skill in the relevant area of medical practice. These are issues which necessarily direct attention to the practice or practices of medical practitioners. And, of course, the current state of medical knowledge will often be relevant in determining the nature of the risk which is said to attract the precise duty in question, including the foreseeability of that risk.

Diagnosis and treatment are but particular duties which arise in the doctor-patient relationship. That relationship also gives rise to a duty to provide information and advice. That duty takes its precise content, in terms of the nature and detail of the information to be provided, from the needs, concerns and circumstances of the patient. In other cases, where, for example, no specific inquiry is made, the duty is to provide the information that would reasonably be required by a person in the position of the patient.

Leaving aside cases involving a medical emergency or a situation where the circumstances of the individual require special consideration, there is no basis for treating the doctor's duty to warn of risks (whether involved in the treatment or procedures proposed or otherwise attending the patient's condition or circumstances) as different in nature or degree from any other duty to warn of real and foreseeable risks. The Judge saw no basis for any

exception or “ therapeutic privilege” which is not based in medical emergency or in considerations of the patient’s ability to receive, understand or properly evaluate the significance of the information that would ordinarily be required with respect to his or her condition or the treatment proposed. The appeal should be dismissed.

Result & Order

The Appeal was dismissed with costs.

The High Court stated that the patient should be told of any material risk inherent in the treatment.

Analysis Of The Decision

The High Court stated that the patient should be told of any material risk inherent in the treatment. A material risk is one to which a reasonable person in the patient’s condition would be likely to attach significance; and to which the healthcarer knows (or ought to know) the particular patient would be likely to attach significance; and about which questions asked by the patient reveal his or her concern.

The court also established that the fact that a person does not insist on information being provided does not reduce the health carer’s duty (or client’s right) that is be provided. This means that health carers must be careful to take account of factors associated with the special needs of clients, “ be they wishes, anxieties or beliefs”. Justice Gaudron stated that where no specific inquiry is made, the duty is to provide the information that would reasonably be required by a person in the position of the client; this requires the health carer to consider what they ought to anticipate as this

particular client' needs, and/or wishes. For example, where the client is a professional player of a musical instrument, one could argue that the health carer ought to anticipate that he or she would have a particular interest in any risk or harm to the hands or fingers.

It was accepted that Ms Whitaker may not have asked the right question to elicit information about sympathetic ophthalmia, but she made clear her concern that nothing should happen to her good eye. The placing of an onus on the patient to ask questions could be considered somewhat unfair, but the matter was not pursued further by the court.

End Notes

1. Meg Wallace, Health Care and the Law, 3ED, Lawbook Co., 2001, p91.
2. Ibid.
3. Ibid.
4. Ibid.
5. Meg Wallace, Health Care and the Law, 3ED, Lawbook Co., 2001, p91.
6. Bolam v Friern Hospital Management Committee [1957] 1 WLR 582. This case gave medical staff the discretion to decide what disclosure is proper and in the patient's interest.
7. Meg Wallace, Health Care and the Law, 3ED, Lawbook Co., 2001, p91
8. Ibid.

9. Ibid.

10. Wyong Shire Council v Shirt (1980), 146 C. L. R. 40.

11. Albrighton v Royal Prince Alfred Hospital, [1980] 2 N. S. W. L. R. 542, at pp. 562-563

12. Sidaway v Bethlem Royal Hospital, [1985] A. C., at pp. 891, 900, 936.

13. F. v R. (1983), 33 S. A. S. R., at p. 191; Reibl v Hughes, [1980] 2 S. C. R. 880; (1980) 114 D. L. R. (3d) 1.

14. Bolam v Friern Hospital Management Committee [1957] 1 WLR 582.

15. F v R (1983) 33 SASR 189.

16. Meg Wallace, Health Care and the Law, 3ED, Lawbook Co., 2001, p92

17. Ibid.

18. Ibid.

19. F v R (1983) 33 SASR 189.

20. See also Ellis v Wallsend District Hospital [1989] Aust Torts Reports 80-259; H v Royal Alexander Hospital for Children & Ors [1990] Aust Torts Reports 81-100.