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"Developments in the law relating to medical negligence in the last 30 years"

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High Court of Australia

Some historical background

The modern law of negligence is based upon a general rule that those whose acts or omissions might injure another should exercise reasonable care to avoid that occurring. The rule is of relatively recent origin and is attributed to a case decided in the early part of the 20th century.

In much earlier times, English law showed no interest in providing compensation for unintended injury. Society had other, more pressing, concerns. By the 19th century there was still no general rule for liability for negligence, but particular callings were identified as subject to potential liability for loss to customers – for example, innkeepers and common carriers, whose liability was strict. Other callings, such as the surgeon or the attorney were subject to a duty of carefulness. A prominent legal historian suggests that the reason why cases involving these two professions do not appear earlier is that it was not until much later "that these professions attained social dignity by measures taken to eliminate quacks in the one case and swindlers in the other."[1]

The Industrial Revolution of the 19th century had a profound effect on the development of the law of negligence. Whilst philosophers debated new theories of individual and societal rights and responsibilities, the courts were grappling with the extent to which industrialists and others should be held liable to compensate for injuries caused by new processes and emergent technologies.

It was not until the 1930s that the modern law of negligence is considered to have emerged. As sometimes happens in our system of precedential law, an unremarkable case was responsible for an important statement of legal principle. In 1928, a Scottish woman became ill after drinking ginger beer which was contaminated by a dead snail. Up to this point a manufacturer could only be

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1 Winfield, "The History of Negligence in the Law of Torts", (1926) 42 *Law Quarterly Review* 184 at 187.

held liable to the purchaser of the product and the ginger beer had not been purchased by the woman, but by her friend. In this case[2] the maker of the ginger beer was held liable to the ultimate consumer of the ginger beer by applying the principle that a duty of care is owed to a person who might be affected by one's negligent acts. The person might be called one's "neighbour". It may be of some interest to note that the English judge who wrote that leading judgment, Lord Atkin, was born, and spent his early life, in Brisbane.

The elements that needed to be proved in the modern action for negligence could now be stated as follows: the existence of a duty of care; a breach of that duty by a negligent act or omission; and damage suffered in consequence. Inherent in these, but often considered separately, is the requirement of a causal connection between breach and damage.

Developments in the last 30 years – an overview

In the 80 years or so since that decision, the High Court of Australia has further developed the law of negligence. In the period about which I shall speak – the period of 30 years in which this Conference has been held – the High Court has considered each of the elements of the action for negligence and it has done so in the context of actions in which medical negligence was alleged.

Medical negligence is not a discrete area of the law, but cases involving allegations of negligence against a medical practitioner quite often throw up difficult questions as to the concepts which inform the elements of the action for negligence.

My starting point is a landmark decision in 1992, *Rogers v Whitaker*[3], which doubtless has been largely responsible for the abundance of information which is now routinely provided to patients about surgery or other treatment. It involved the extent of information which should be provided about the risks of treatment. The legal question was the content, or extent, of the duty of care owed to the patient when advising about treatment.

My next topic is the problematic question of causation. Causation is the connection necessary, for there to be liability, between an act of negligence and the damage suffered. It is a conclusion about legal responsibility. In the period in question, the High Court discussed the tests for it.

The remaining element to be discussed concerns the nature of "damage". The law does not recognise every kind of harm or loss as warranting compensation. I shall discuss three novel claims of damage.

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[2] *Donoghue v Stevenson* [1932] AC 562.

[3] (1992) 175 CLR 479; [1992] HCA 58.

In the course of my discussion of these elements, I will refer to aspects of legislation which was introduced in the latter part of the period, for the purpose of limiting liability. You may recall an inquiry into the rising costs of indemnity and other insurance. It led to the introduction of the *Civil Liability Act* 2002 in New South Wales and the other States and Territories followed suit. I will comment upon whether this legislation has effected any substantial changes to the law as developed by the High Court.

In my conclusion, I will touch upon the interconnectedness of the elements of the action as relevant to the development of the law.

Duty and standard of care – *Rogers v Whitaker*

The salient facts of *Rogers v Whitaker* are as follows. The patient had injured her right eye in a childhood accident. An ophthalmic surgeon advised her that an operation on the eye would not only improve its appearance, it would probably also substantially restore sight to it. The operation was not successful in that regard, but it was performed with the requisite care and skill. However, the patient suffered sympathetic ophthalmia post-operatively and as a result of inflammation arising from this lost all sight in the left eye. She became almost totally blind.

In Australia it had been accepted that the standard of care to be observed by a professional person is that of the ordinary skilled person exercising and professing to have that special skill. The question in this case was whether the observance of that standard of care required information regarding the risk associated with the aftermath of surgery to be given to the patient.

The ophthalmic surgeon gave evidence that it had not occurred to him to mention sympathetic ophthalmia to the patient. There was a body of evidence from other medical practitioners to like effect; but there was also evidence from others that they would have given a warning. The state of the evidence may itself have signalled to the Court that the old rule was unsustainable.

In England the approach to the resolution of similar problems had been determined by a case which lends its name to the *Bolam* rule[4]. The case, which was heard in the 1950s, involved a patient who was injured whilst receiving ECT treatment without the prior administration of a relaxant drug. Evidence as to the practice to be followed varied as between doctors, leading the Court to formulate a rule that has since been stated as[5]:

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[4] *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582; [1957] 2 All ER 118.

[5] As restated in *Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 871 at 881 per Lord Scarman.

> "a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment." (emphasis added)

It followed from this rule that so long as a sufficient number of medical practitioners adopted the practice in question, the practitioner sued would have a complete defence. It may be observed that the *Bolam* rule is directed to accepted practice in the actual provision of treatment, whereas *Rogers v Whitaker* was concerned with advice about risks involved in treatment. In cases decided after *Bolam* some judges expressed the view that the rule should only apply in cases involving negligent treatment or surgery, but not where the issue was the quality of the advice or information given. In *Rogers v Whitaker* the Court decided that the rule should be restricted in that way.

In relation to diagnosis and treatment, the Court accepted that the *Bolam* rule would continue to be influential, for the reason that whether a diagnosis or a method of treatment was negligent would depend largely upon medical standards, which are known best by doctors. The question whether a risk is relevant to a patient, and one about which they should be warned, is different. The High Court said that the courts are able to determine this question themselves.

Influential to this ruling was the view that a person is entitled to make informed decisions about his or her life. A patient must therefore be informed of "material risks". A risk is material, the Court said, if a reasonable person in the patient's position would be likely to attach significance to it or the doctor should be aware that this patient would do so. In the case in question, it would be reasonable for a person with one good eye to be concerned about the possibility of injury to it, especially in the context of a procedure which was elective.

What the Court said about a patient's right to exercise a personal choice in taking the risks of a surgical procedure should not be misunderstood. The Court was not basing its decision on notions of human rights. In a decision in 2013, which I shall shortly discuss, it made this clear[6]. Damages are not awarded for breach of a human right, but for breach of professional duty.

In *Rogers v Whitaker*, the Court did not entirely rule out the exercise of judgment, on the part of a doctor, as to what information is to be given to particular patients and how it is to be conveyed. The qualification it made to the duty owed to patients to give information about risks was where there was a

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[6] *Wallace v Kam* (2013) 250 CLR 375 at 381 [9]; [2013] HCA 19.

danger that the provision of all information would harm an unusually nervous, disturbed or volatile patient.

The *Civil Liability Act*, to which I have earlier referred, addresses the application of the *Bolam* rule. It provides[7] that a professional person does not incur liability in negligence "if it is established that the professional acted in a manner that (at the time the service was provided) was widely accepted in Australia by peer professional opinion as competent professional practice", so long as the practice is not "irrational". The Act does not define what is "widely accepted". It provides merely that the fact that there are differing opinions does not prevent an opinion qualifying[8] and that peer professional opinion does not have to be universally accepted to be widely accepted[9].

It is not clear whether those drafting the *Civil Liability Act* thought that they were effecting a major departure from *Rogers v Whitaker*. If they did, they would appear to be mistaken, for it is also provided in the Act[10] that the provisions relating to peer professional opinion do not apply to a failure by a professional to give a warning, advice or other information regarding a risk of injury or death to a person, which of course was the very issue in *Rogers v Whitaker*. You will recall that it was not suggested in *Rogers v Whitaker* that the *Bolam* rule should not apply in cases involving negligent diagnosis or methods of treatment. All the legislation appears to have done is to raise the bar of the *Bolam* rule when it applies, from a practice that is accepted as proper by a responsible body of medical opinion, to one which is widely accepted.

Causation

To succeed in an action for negligence it is not sufficient to prove an act of negligence, constituting a breach of the duty of care. It is necessary to show that it caused the damage in question.

The law's treatment of causation differs from its treatment in science or philosophy. The law is not concerned to explain, as science does, physical phenomena by reference to conditions and occurrences. The law is concerned with ascribing, ex post facto, personal responsibility.

It had been accepted at the trial in *Rogers v Whitaker* that the patient would not have undergone surgery had she been warned of the risk of

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7 *Civil Liability Act* 2002 (NSW), s 5O.

8 *Civil Liability Act* 2002, s 5O(3).

9 *Civil Liability Act* 2002, s 5O(4).

10 *Civil Liability Act* 2002, s 5P.

sympathetic ophthalmia. Two conclusions relevant to the approach of the law to proof of causation follow from this. In the first place, she would not in fact have suffered the injury but for the failure to warn. Secondly, she would not have been prepared to take the risk of loss of her sight. In these circumstances there is no reason why the practitioner should not be held liable for the failure to warn, when a warning would have avoided this consequence.

As this indicates, the question of causation is approached by the common law in two steps.

The first enquiry is as to causation in fact. It is an historical enquiry, as to how the injury or harm suffered came about. It looks to the causae sine qua non – the factors without which the damage would not have occurred – to provide the necessary connection between a negligent act and injury. If the negligent act is a necessary condition for the event giving rise to injury, it is a cause in fact.

This translates to the "but for" test. Applied negatively, it asks whether the injury would not have occurred "but for" the defendant's negligence. If the damage would have occurred notwithstanding the negligent act or omission, the act or omission is not a cause. It has been said[11] that courts throughout the world agree that the relation of necessity between breach and outcome, expressed as the "but for" test, is the one the law should designate as causal.

The second enquiry is whether, regardless of factual causation, a defendant should be held legally responsible for his or her breach of duty. This is a purely legal question, involving policy concerns and, to an extent, a value judgment. It may involve consideration of the degree of connection between breach and injury.

In most cases it will be obvious that a defendant should be held liable for a breach which has contributed to an injury. The second enquiry assumes significance in more difficult cases.

The two enquiries operate in this way: if the breach did in fact contribute to the injury, should the defendant be held legally responsible for it?

The *Civil Liability Act* does not ignore the topic of causation, but made no real change to the common law. It does not depart from the two tests applied by the courts, which the Act calls "factual causation" and "scope of liability". The High Court has observed that the first stage of the statutory test involves

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[11] Stapleton, "Reflections on Common Sense Causation in Australia", in Degeling, Edelman and Goudkamp (eds), *Torts in Commercial Law*, (2011) 331 at 338.

"nothing more or less than the application of a 'but for' test of causation"[12]. And so far as concerns the second enquiry, the Court said that the statutory provisions do not displace the methodology of the common law[13].

The tests of causation may seem straightforward enough. The difficulty arises in their application to the facts of particular cases. In cases where it is alleged that there has been a failure to warn of one or more material risks inherent in a proposed treatment, the Court has explained[14] that the question of factual causation is largely governed by what the patient would have chosen to do.

The Court identified three factual scenarios as illustrative of past cases[15].

- In the first, the patient would have chosen to undergo the treatment even if warned of all material risks. Here there can be no finding of factual causation, because physical injury associated with the risk which materialised would have occurred even if the patient was warned;

- the second is where it is found that the patient would have chosen not to have treatment if warned. *Rogers v Whitaker* falls into this category. Where the patient has suffered injury, a finding of causation can be made without difficulty. But for the failure to warn, the patient would not have been exposed to the risk which materialised;

- the third example is more problematic. It refers to the circumstance where the patient would have chosen not to undergo treatment at this time. Here the nature of the risk remains the same. This scenario can only arise in an unusual circumstance where the likelihood of injury can be said to be different at different times, by reason of some variable factor affecting the outcomes.

An example of the last scenario is provided by the decision in *Chappel v Hart*[16]. In this case, an ear, nose and throat surgeon performed an operation with all due care and skill, but the patient's oesophagus was perforated in the

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12 *Wallace v Kam* (2013) 250 CLR 375 at 383 [16].

13 *Wallace v Kam* (2013) 250 CLR 375 at 385 [22].

14 *Wallace v Kam* (2013) 250 CLR 375 at 383 [17].

15 *Wallace v Kam* (2013) 250 CLR 375 at 384 [18]-[20].

16 (1998) 195 CLR 232; [1998] HCA 55.

process. An infection developed and damaged the laryngeal nerve, which led to paralysis of the right vocal chord. The patient had specifically asked about the risk of injury to her voice. The specialist mentioned the risk of perforation, but not the risk of complicating infections. There was some evidence that the chance of perforation bore some relationship to the degree of skill of the surgeon, but the risk of infection was extremely rare. The patient said that had she been warned, she would not have undergone the surgery when she did and would have waited to engage the most experienced surgeon.

Could it be said that "but for" the failure to warn, the patient would not have suffered the infection consequent upon the perforation? It was generally accepted that the patient's condition was such that surgery would inevitably be required. At most, therefore, the failure to warn put the patient into surgery at an earlier time. The Court was divided on this question.

A majority of the Court held the surgeon liable on the basis of the patient's evidence that had she been warned of the risk she would have waited and obtained the most experienced surgeon. But this reasoning exposed an evidentiary difficulty. As the judges in the minority pointed out, it is up to the person claiming, the patient, to show that this would have likely made a difference. There was no evidence that other surgeons could have performed the procedure with greater care and skill and there was no evidence that a surgeon would never perforate the oesophagus. To hold the defendant surgeon liable would seem to involve a reversal of the onus of proof.

The second enquiry of causation does not appear to have assumed much importance in the decision. However, it might be seen to identify the difficulty in holding the surgeon liable. It would ask: why should the surgeon be held liable for the materialisation of an extremely rare risk of infection? Should he be liable for failing to warn of a risk of this kind?

The second case to which I will refer, which explained the approach to be taken to both enquiries, is *Wallace v Kam*. By the time of this decision the *Civil Liability Act* had come into operation. Relevantly, the Act does two things.

It restates the requirement of the common law that the person claiming always bears the onus of proving any fact relevant to causation[17]. This provision may have been a response to *Chappel v Hart*. The Act also[18] rejects use of self-serving evidence by plaintiffs in favour of a hypothetical assessment of what the person would or would not have done. It left the courts to determine this question. The courts have at any rate usually discounted self-serving evidence as inherently unreliable and have looked to objective factors,

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[17] *Civil Liability Act* 2002, s 5E.

[18] *Civil Liability Act* 2002, s 5D(3).

such as whether the treatment was inevitable or not, in order to determine whether a person would have undertaken it and any attendant risks.

In *Wallace v Kam*, the patient was not warned of two risks inherent in the treatment proposed: bilateral femoral neurapraxia, resulting from lying face down on the operating table for an extended period; and a one-in-twenty chance of permanent and catastrophic paralysis resulting from damage to the spinal nerves. The patient suffered neurapraxia, but not paralysis.

It was argued for the patient that liability could arise from failure to warn of all the risks, no matter which materialised. If he had been warned of the risk of paralysis he would not have had the surgery. On this argument it would be enough for a conclusion of factual causation that there be a failure to advise of the risk. It does not need to be the risk that eventuates. But that is to misunderstand both the test of factual causation and the further question of legal policy. The first is concerned with what caused the injury which resulted and the second asks whether the defendant should be held liable for the materialisation of the risk of that injury.

The limitation of relying only on factual causal inquiry was explained by the High Court by way of an example often referred to in this context[19]. A mountaineer is negligently advised by his doctor that his knee is fit to make a difficult climb. He makes the climb, which he would not have made if properly advised about his knee, only to be injured in an avalanche. His injury is a foreseeable consequence of mountaineering, but has nothing to do with his knee. Why should the doctor be held responsible for all the risks inherent in mountain climbing?

With respect to the second, legal, enquiry of causation, the Court identified as relevant the particular damage the patient had suffered, because that is what the law compensates for. The patient suffered neurapraxia. The Court considered that the patient would most likely have regarded the risk of neurapraxia as acceptable. Why should the doctor be held liable for the materialisation of a risk which the patient was prepared to take? The patient's action failed.

Novel cases of damages

This brings me to the question of the type of damage which is recognised by the law of negligence. Damage, in the sense of injury or harm suffered, is the gist of, and essential to, an action for negligence. "Damage" in this sense is different from "damages", which refers to the money which is awarded to compensate for the injury or harm.

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[19] See *Wallace v Kam* (2013) 250 CLR 375 at 386 [24]; see authorities referred to in fn 38.

To determine whether, and the extent to which, a person has suffered damage, the law looks to the position of the person before and after the occurrence of the injury or harm caused by the negligent act. Generally speaking, in the law of negligence damage may be quantifiable injury or harm to a person, to property or to a person's interests. In cases of medical negligence it will usually be bodily injury or harm.

In the last 10 years or so there have been three cases before the High Court which have challenged accepted notions of damage. The first question for the Court was whether the damage fell within a category already recognised by the common law. If it did not, could and should the common law be extended to recognise such damage? Once again, we are in the territory of legal policy.

A court such as the High Court is responsible for developments in the Australian common law. Developments in a system which relies on precedent – what is learned or distilled from case to case – tend to be incremental. That is because of the nature of the system and the concern of the law to at least have the appearance of coherence and certainty. New directions have to be explicable by reference to established principles which inhere in actions such as those for negligence. Arguments which seek to alter the elements of the cause of action or their relationship to each other are carefully scrutinised.

In two of the three cases, novel claims of damage were advanced, but did not succeed.

One of the cases, *Tabet v Gett*[20], involved a child who had suffered severe, irreversible brain damage. By the time the appeal reached the High Court it was accepted by the parties that the treating doctor at the hospital should have ordered a scan at an earlier time. It would have revealed a brain tumour.

Lawyers acting for the child recognised that there were problems with causation in her case. The evidence did not establish the necessary connection between the delay in treatment, which resulted from the failure to order a scan, and the subsequent brain damage. It could not be said on the balance of probabilities that "but for" the delay, the child would not have suffered brain damage.

The lawyers turned their attention to another kind of damage. They argued that she had suffered a loss of a kind different from the brain injury. Because of the delay in diagnosing her condition, she had suffered the loss of the possibility of a better medical outcome, they contended.

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[20] (2010) 240 CLR 537; [2010] HCA 12.

Characterising the damage in this way still could not overcome problems with evidence of causation. At an evidentiary level there is always a degree of speculation necessarily involved in accepting that there would have been a better outcome if a patient had received better advice.

There were other matters of principle at stake as well. A chance is only a possibility. In civil actions such as those for negligence, the standard of proof is the balance of probabilities. It is necessary for a plaintiff to show, on the balance of probabilities, that damage would not have occurred had the doctor not been negligent. To accommodate the loss of a chance of a better medical outcome as compensable damage, the court would have to lower the standard of proof in all actions for negligence, from a probability to a chance. Framing the damage as loss of a "chance" adverts to the fact that what is involved is possibilities rather than probabilities. The concept of causation would also have to be redefined, to accommodate a chance. These were large steps which could have far-reaching effects. The Court did not consider that there was reason shown why, as a matter of policy, it should make these fundamental changes to the law. This decision may have been a relief to doctors in Australia, and their insurers, given that the chance of mishap is inherent in most medical procedures.

Difficult questions were also raised about the concept of "damage" in the second case, *Harriton v Stephens*[21]. An action was brought on behalf of a child who had been born with congenital abnormalities caused by the rubella virus contracted by her mother during pregnancy. The virus was not diagnosed by the mother's doctor. It was accepted that had the mother been informed of the presence of the virus and the risk of abnormalities she would have terminated the pregnancy.

To say that a person has suffered damage is to invite a comparison between what would have been and what now is. A simple example, such as might arise in a case involving a motor vehicle accident, is the comparison between a pain-free, unimpaired person before a negligent act and a person with a fractured limb having limited movement after. The child's lawyers sought to demonstrate that she had suffered damage by using a comparison of a different kind. It involved the child's condition now, being disabled, and the circumstance which would have followed had her mother been advised of the presence of the virus and terminated the pregnancy. But this was to compare the state of the child as at the time of the case with a state of not being born. The High Court held that a comparison which involves non-existence is impossible to accept. This might be thought to involve an element of moral philosophy. It is probably sufficient to observe that the comparison contended for could not logically prove damage, as a person cannot complain that they should not exist.

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[21] (2006) 226 CLR 52 [2006] HCA 15.

In the third case, *Cattanach v Melchior*[22], the plaintiff was successful. A child had been born after a failed sterilisation procedure. The parents claimed as damages the reasonable cost of raising and maintaining an unplanned child. The question was whether the parents had suffered damage by these costs.

It was argued that the parents could not be said to have suffered harm or damage, given the immeasurable benefits which they admittedly derived from the child. On this view there was no real loss or damage. The argument had received some judicial support in England. But as the High Court considered, it could hardly be said that the birth had no effect upon the parents. The mother suffered pain and suffering in childbirth and could be compensated for that. The parents also had to pay for the medical and hospital costs of the birth. Logically, there was nothing to prevent compensation for the effect upon their other interests, constituted by the burden of responsibility which had been imposed upon them by the unplanned birth. The costs of the child's upbringing were allowed.

Conclusion

Each of the medical negligence cases I have discussed today has contributed in some way to the development of the general law relating to negligence. Development in this sense is not to be equated with an expansion of liability, or a contraction of it for that matter. It refers to the way each case, decided by reference to the facts relevant to it, adds to the body of knowledge which may later become distilled as a rule, a test or a legal principle. Problems which arise in connection with one or more of the elements of the action are worked out. Development, by way of further statement, clarification or explanation of the law, tends to be incremental.

In deciding difficult cases of this kind the elements of the action must be viewed not separately, but as interconnected and working together. Thus the first case stated the duty owed as a duty to warn of material risks. Identifying the duty in that way also facilitates the determination of causation, based on what risks a patient would likely have taken, or not taken. This was picked up and explained in the later cases. In one of them, the resolution of the question of causation brought into focus the connection necessary between the particular injury suffered, and the risk not warned about. The cases concerned with the nature of damage itself show that the Court will consider the changes which would be necessary with respect to the action for negligence should the notion of damage be enlarged. And they show that the Court will be cautious about change where coherence in the law may be lost.

The cases discussed did not come to the attention of the High Court for decision by chance. As many of you would know, appeals to the Court are

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[22] (2003) 215 CLR 1; [2003] HCA 58.

subjected to the filtering mechanism of special leave. This requires a party to persuade two or three justices of the Court that the case involves a matter of general importance to the law. This criterion may be satisfied where a question of legal principle is involved and where there will be an opportunity for the Court to clarify, explain or develop the existing case law.

Who knows what the action for negligence will look like in another 100 years. The law responds, to an extent, to the demands of the particular age. The law of medical negligence, in particular, will need to be responsive to developments in technology and scientific understanding. We can, however, look back over the last 30 years and observe not only how change is effected but also how constancy is maintained.