

MEDICAL NEGLIGENCE, CAUSATION AND LIABILITY FOR NON-DISCLOSURE OF RISK: A POST-WALLACE FRAMEWORK AND CRITIQUE

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I INTRODUCTION

It is well-established under the Australian law of negligence that medical practitioners owe a comprehensive duty of care to patients. The duty encompasses all aspects of their role and requires practitioners to take reasonable care in the provision of diagnosis, treatment, and information and advice.¹ In respect of the latter part of this duty, the High Court in *Rogers v Whitaker* imposed an obligation upon practitioners to disclose to patients all material risks inherent in undergoing or forgoing surgery or other interventions.² An inherent risk of a procedure is one which ‘cannot be avoided by’ the practitioner’s ‘exercise of reasonable care and skill’,³ and the majority in *Rogers v Whitaker* observed that a risk is classed as material if

in the circumstances of the particular case, a reasonable person in the patient’s position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it.⁴

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1 *Rogers v Whitaker* (1992) 175 CLR 479, 483 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ), 492 (Gaudron J).

2 Ibid 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

3 See, eg, *Paul v Cooke* (2013) 85 NSWLR 167, 182 (Leeming JA), 172 (Ward JA agreeing). See also at 171 (Basten JA); *Cox v Fellows* [2013] NSWCA 206, [189] (Gleeson JA). Legislation excluding liability in negligence ‘for harm suffered by another person as a result of the materialisation of an inherent risk’ does not apply in this context: *Civil Liability Act 2002* (NSW) s 51. See also *Civil Liability Act 2003* (Qld) s 16; *Civil Liability Act 1936* (SA) s 39; *Wrongs Act 1958* (Vic) s 55; *Civil Liability Act 2002* (WA) s 5P.

4 (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). See also at 493 (Gaudron J).

As confirmed by the *Review of the Law of Negligence*,⁵ and statute enacted in some jurisdictions,⁶ this duty to warn of material risks is both proactive and reactive. The proactive duty requires the doctor to volunteer information which he or she considers to be material to the reasonable patient (an objective test). The reactive duty requires the doctor to provide information in response to a particular patient's circumstances, or their specific concerns or questions (a subjective test). Notably then, standards of risk disclosure in Australia are not dictated by those judged acceptable by the medical profession.⁷ Rather, the courts have adopted a patient-centred approach to this aspect of the practitioner's duty of care with the stated aim of empowering patients 'to make their own decisions about important procedures to be undertaken on their bodies' on the basis of information about material risks relevant to them.⁸ Consequently, whether a risk is material may depend upon: the likelihood and seriousness of the risk to be disclosed; the nature and/or necessity of the treatment being provided; the patient's desire for information; the patient's health and temperament; and general matters, such as alternative sources of advice or treatment.⁹

The approach to determining whether a risk is material in a particular case is well-established under Australian law. This is arguably supported by Bismark et al who in 2012 concluded, from a sample of approximately 10 000 malpractice claims and conciliated healthcare complaints, that of the 375 disputes relating to non-disclosure of risk, only 45 involved 'disagreements between patients and

5 David Andrew Ipp, Australian Treasury, *Review of the Law of Negligence: Final Report* (2002) 48–53 ('Ipp Report').

6 See *Civil Liability Act 2003* (Qld) s 21; *Civil Liability Act 2002* (Tas) s 21, which apply to 'doctors' and 'registered medical practitioners' respectively. Section 50 of the *Wrongs Act 1958* (Vic) provides that 'a person (the defendant) who owes a duty of care ... to give a warning or other information to the plaintiff in respect of a risk or other matter, satisfies that duty ... if the defendant takes reasonable care in giving that warning or other information'. While this provision is wider than that in the other jurisdictions, in a medical context, it would appear to operate consistently with the test for when a risk is material determined by the High Court in *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

7 *Rogers v Whitaker* (1992) 175 CLR 479, 487 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). In fact, statutes providing for the use of peer professional opinion in the determination of the breach of a professional's standard of care specifically exclude the use of such opinion in relation to 'liability arising in connection with the giving of (or the failure to give) a warning, advice or other information in respect of the risk of death of or injury to a person': *Civil Liability Act 2002* (NSW) s 5P. See also *Civil Liability Act 2003* (Qld) s 22(5); *Civil Liability Act 1936* (SA) s 41(5); *Civil Liability Act 2002* (Tas) s 22(5); *Wrongs Act 1958* (Vic) s 60; *Civil Liability Act 2002* (WA) s 5PB(2).

8 Ian Freckleton, 'Rogers v Whitaker Reconsidered' (2001) 9 *Journal of Law and Medicine* 5, 11. See also *Rogers v Whitaker* (1992) 175 CLR 479, 482 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ); *Chappel v Hart* (1998) 195 CLR 232, 271–2, 276 (Kirby J); *Rosenberg v Percival* (2001) 205 CLR 434, 477 (Kirby J).

9 *F v R* (1983) 33 SASR 189, 192 ff (King CJ), affd *Rogers v Whitaker* (1992) 175 CLR 479, 488, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). See, eg, *Rosenberg v Percival* (2001) 205 CLR 434; *KL v Farnsworth* [2002] NSWSC 382; *Henderson v Low* [2001] QSC 496; *Johnson v Biggs* [2000] NSWCA 338; Thomas Addison, 'Negligent Failure to Inform: Developments in the Law since *Rogers v Whitaker*' (2003) 11 *Torts Law Journal* 165, 167–80.

clinicians over whether a risk ought to have been disclosed'.¹⁰ In the remaining disputes, the practitioner either: conceded liability; claimed that responsibility to disclose lay with another; contended that the risk had been disclosed; or denied liability on the basis that the failure to disclose had not caused the patient's harm.¹¹ Similarly, in *Wallace v Kam*¹² there was no question on appeal as to whether the specific risks involved were considered to be material. The key issue for determination by the High Court was whether causation could be established.¹³ However, the particular negligence claim in *Wallace v Kam* was unlike other non-disclosure cases requiring a consideration of causation. Not only was *Wallace v Kam* the first High Court decision on risk non-disclosure pursuant to the civil liability legislation's causation provisions,¹⁴ but its particular factual matrix also made it unique in Australian law.

As with any negligence claim, a patient who alleges that a medical practitioner is liable for failing to warn of a procedure's material risk(s) must establish that the duty owed was breached (that is, that a material risk was not disclosed) and that the harm sustained was caused by that breach. A finding of causation in such cases commonly hinges upon the patient establishing that, had they been disclosed pursuant to the practitioner's duty of care, the patient would not have suffered injury in the form of the physical manifestation of one or more risks inherent in the procedure. This is because each occurring risk would have individually resulted in the patient delaying or refusing the treatment.¹⁵ *Wallace v Kam* instead required an assessment of whether a practitioner's liability should extend to the situation where a patient would not have undergone treatment if all material risks had been disclosed, but would have still undergone treatment at the same time and place if warned only of the risk that ultimately transpired.¹⁶

10 Marie M Bismark et al, 'Legal Disputes over Duties to Disclose Treatment Risks to Patients: A Review of Negligence Claims and Complaints in Australia' (2012) 9(8) *PLOS Medicine* 1, 2.

11 Ibid 3.

12 (2013) 250 CLR 375.

13 Ibid 379, 387. See also *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 045 [8], 66 047 [14], 66 052 [46], 66 054–55[66]–[69], 66 065 [136]. Discussed below nn 56–60, 63 and accompanying text.

14 Discussed below Part II.

15 See, eg, *Elbourne v Gibbs* [2006] NSWCA 127, where the patient claimed that the defendant surgeon had failed to warn him of a number of material risks of surgery to repair bilateral inguinal hernias which, in fact, materialised. The risks included: gross swelling of the scrotum; chronic pain resulting from nerve entrapment; and embolism. Evidence was given in relation to each risk that the patient 'would not have undergone the operation if he had been properly warned': at [34]–[37] (Basten JA), [1] (Beazley JA agreeing). See also at [97], [105] (Basten JA); *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553, 578–9, 582–90 (Samuels JA), 607 (Meagher JA agreeing) (non-disclosure of a risk of paralysis and failure to relieve pain following surgery, in circumstances where the patient would not have undergone the procedure and sustained quadriplegia had the slight paralysis risk been known). In the context of delayed surgery, see, eg, *Chappel v Hart* (1998) 195 CLR 232 (failure to warn of injury to the patient's voice consequent upon infection occurring after perforation of the oesophagus during throat surgery), discussed further below nn 160, 183, 236, 285 and accompanying text.

16 (2013) 250 CLR 375, 387 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

Through an examination of *Wallace v Kam*, this article considers and evaluates the law of causation in the specific context of a medical practitioner's duty to provide information to patients concerning material risks of treatment. To supply a contextual background for the analysis which follows, Part II summarises the basic principles of causation law, while Part III provides an overview of the case and the reasoning adopted in the decisions at first instance and on appeal. With particular emphasis upon the reasoning in the courts of appeal,¹⁷ Part IV then examines the implications of the case in the context of other jurisprudence in this field and, in so doing, provides a framework for a structured consideration of causation issues in future non-disclosure cases under the Australian civil liability legislation. As will become clear, *Wallace* was fundamentally decided on the basis of policy reasoning centred upon the purpose behind the legal duty violated. Although the plurality in *Rogers v Whitaker* rejected the utility of expressions such as 'the patient's right of self-determination'¹⁸ in this context, some Australian jurisprudence may be thought to frame the practitioner's duty to warn in terms of promoting a patient's autonomy, or right to decide whether to submit to treatment proposed. Accordingly, the impact of *Wallace* upon the protection of this right, and the interrelation between it and the purpose of the duty to warn, is investigated.¹⁹ The analysis in Part IV also evaluates the courts' reasoning in *Wallace* by questioning the extent to which *Wallace*'s approach to liability and causal connection in non-disclosure of risk cases depends upon the nature and classification of the risk(s) in question, and can be reconciled with the way in which patients make decisions. Finally, Part V adopts a comparative approach by considering whether the same decision might be reached if *Wallace* was determined according to English law.

II CAUSATION: BASIC PRINCIPLES

At law, causation arises in the context of assigning legal responsibility for a particular act or omission,²⁰ and requires a determination of whether a defendant's conduct played a part in bringing about the harm that is the subject of the claimant's negligence action. As such, it is not resolved according to the

17 For the remainder of this article, the term *Wallace* is used to refer to the case generally on appeal (in the NSW Court of Appeal and in the High Court of Australia), unless indicated otherwise.

18 (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ) (citations omitted). Indeed their Honours stated that 'nothing is to be gained by reiterating [such] expressions [as] used in American authorities'. Amongst American authorities, see, eg, *Canterbury v Spence*, 464 F 2d 772, 780, 786-7 (DC Cir, 1972).

19 See discussion below Part IV(B).

20 *March v E & M H Stramare Pty Ltd* (1991) 171 CLR 506, 509, 514 (Mason CJ); *Chappel v Hart* (1998) 195 CLR 232, 238 (Gaudron J); *Wallace v Kam* (2013) 250 CLR 375, 381 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

‘relationship between conditions and occurrences’ prescribed by scientific or philosophical theory.²¹ Instead, it is based upon a consideration of the facts of a particular case when viewed in light of ‘the practical way in which the ordinary man’s mind works in the every-day affairs of life’.²² For this purpose then, the common law has always recognised that there are ‘two fundamental questions involved in the determination of causation in tort’.²³

The first relates to the factual aspect of causation, namely, the aspect that is concerned with whether the negligent conduct in question played a part in bringing about the harm, the subject of the claim ... The second aspect concerns ‘the “appropriate” scope of liability for the consequences of tortious conduct’. In other words, the ultimate question to be answered when addressing the second aspect is a normative one, namely, whether the defendant *ought* to be held liable to pay damages for that harm.²⁴

These elements are now apparent in sections 5D(1)(a) and (b) respectively of the *Civil Liability Act 2002* (NSW). Accordingly, the statutory provisions relevant to determining causation in New South Wales (and the equivalent provisions in other jurisdictions)²⁵ have been stated to, in general terms, reflect

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- 21 *March v E & M H Stramare Pty Ltd* (1991) 171 CLR 506, 509 (Mason CJ). See also at 522 (Deane J), 529 (McHugh J); *Chappel v Hart* (1998) 195 CLR 232, 238 (Gaudron J), 242 (McHugh J), 255 (Gummow J), 268–9 (Kirby J); *Roads and Traffic Authority v Royal* (2008) 245 ALR 653, 687 (Kiefel J); *Adeels Palace Pty Ltd v Moubarak* (2009) 239 CLR 420, 443 (French CJ, Gummow, Hayne, Heydon and Crennan JJ); *Amaca Pty Ltd v Ellis* (2010) 240 CLR 111, 121–2, 128 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).
 - 22 *Fairchild v Glenhaven Funeral Services Ltd* [2002] 3 All ER 305, 321 (Lord Bingham), quoting *McGhee v National Coal Board* [1972] 3 All ER 1008, 1011 (Lord Reid).
 - 23 *Ruddock v Taylor* (2003) 58 NSWLR 269, 286 (Ipp JA) (in the context of a false imprisonment claim).
 - 24 *Ibid* (emphasis in original) (citations omitted). See also *Pledge v Roads and Traffic Authority* (2004) 205 ALR 56, 59 (Hayne J); Jane Stapleton, ‘Cause in Fact and the Scope of Liability for Consequences’ (2003) 119 *Law Quarterly Review* 388, 388–9, 411.
 - 25 *Civil Liability Act 2002* (NSW) ss 5D(1), (4); *Civil Liability Act 2003* (Qld) ss 11(1), (4); *Wrongs Act 1958* (Vic) ss 51(1), (4); *Civil Liability Act 1936* (SA) ss 34(1), (3); *Civil Liability Act 2002* (WA) ss 5C(1), (4); *Civil Liability Act 2002* (Tas) ss 13(1), (4); *Civil Law (Wrongs) Act 2002* (ACT) ss 45 (1), (3). Subsection (2) of the legislation in each jurisdiction provides principles relevant to a determination of factual causation in exceptional or appropriate cases falling outside sub-s (1). However, such circumstances did not fall for consideration in *Wallace v Kam* (2013) 250 CLR 375, 384, 387 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). For the purpose of this article, the *Civil Liability Act 2002* (NSW) is predominantly referred to given that it was the legislation relevant to the decision in *Wallace*.

the common law.²⁶ Thus, in order to establish liability, including that for non-disclosure of risk, section 5D(1)(a) first requires a claimant to prove ‘factual causation’, or that the defendant’s negligence was ‘a necessary condition of the occurrence of the [claimant’s] harm’. As a necessary condition is ‘a condition that must be present for the occurrence of the harm’,²⁷ causation will be established under this section if, on the balance of probabilities,²⁸ the claimant’s harm would not have occurred ‘but for’ the defendant’s breach of his or her duty of care.²⁹

At common law, while ‘useful in defining the outer limits of liability where causation is contested’, the ‘but for’ test was never regarded as a comprehensive test of factual causation.³⁰ Rather, it was considered that the results the test yielded required tempering by common sense, or ‘the making of value judgments’,³¹ such that normative issues could influence findings of factual cause.³² The selection, for the purpose of attributing legal responsibility, ‘of those

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- 26 *Finch v Rogers* [2004] NSWSC 39, [146] (Kirby J); *Ruddock v Taylor* (2003) 58 NSWLR 269, 286 (Ipp J) (the principles embodied in s 5D of the *Civil Liability Act 2002* (NSW) ‘are in accord with the common law’); cf *French v QBE Insurance (Australia) Ltd* (2011) 58 MVR 214, 250 (Fryberg J). However, at common law, issues of factual causation and scope of liability were not always separately considered as they are now: see below nn 30–48, 80–1 and accompanying text. In addition, at common law, a claimant’s direct testimony on the issue of causation was allowed. However, as discussed further below nn 143–51 and accompanying text, in order to protect against hindsight bias and the possible self-serving nature of such testimony, s 5D(3)(b) of the *Civil Liability Act 2002* (NSW) (and its equivalent in other jurisdictions) now provides that while the issue of whether, irrespective of a defendant’s negligence, a claimant would have been injured just the same remains subjective, any statement made by the claimant about what they would have done ‘but for’ that negligence is inadmissible, unless against their interest. For a discussion of the position at common law, see *Chappel v Hart* (1998) 195 CLR 232, 272–3 (Kirby J); *Rosenberg v Percival* (2001) 205 CLR 434, 443–4, 449 (McHugh J), 461–2 (Gummow J), 485–7 (Kirby J), 501–2, 504–5 (Callinan J).
- 27 *Strong v Woolworths Ltd* (2012) 246 CLR 182, 191 (French CJ, Gummow, Crennan and Bell JJ). See also at 199 (Heydon J).
- 28 See, eg, *Civil Liability Act 2002* (NSW) s 5E; *Civil Liability Act 2003* (Qld) s 12; *Wrongs Act 1958* (Vic) s 52; *Civil Liability Act 1936* (SA) s 35; *Civil Liability Act 2002* (WA) s 5D; *Civil Liability Act 2002* (Tas) s 14; *Civil Law (Wrongs) Act 2002* (ACT) s 46. See also, at common law, *Amaca Pty Ltd v Ellis* (2010) 240 CLR 111, 123 (French CJ, Gummow, Hayne, Heydon, Crennan, Kiefel and Bell JJ); *Tabet v Gett* (2010) 240 CLR 537, 578 (Kiefel J), 564 (Hayne and Bell JJ agreeing), 575 (Crennan J agreeing).
- 29 See, eg, *Strong v Woolworths Ltd* (2012) 246 CLR 182, 190 (French CJ, Gummow, Crennan and Bell JJ); *Adeels Palace Pty Ltd v Moubarak* (2009) 239 CLR 420, 440, 442–3 (French CJ, Gummow, Hayne, Heydon and Crennan JJ).
- 30 *Roads and Traffic Authority v Royal* (2008) 245 ALR 653, 674 (Kirby J). See also at 663 (Gummow, Hayne and Heydon JJ), 687 (Kiefel J); *Strong v Woolworths Ltd* (2012) 246 CLR 182, 190–1 (French CJ, Gummow, Crennan and Bell JJ); *Travel Compensation Fund v Tambree* (2005) 224 CLR 627, 638 (Gleeson CJ).
- 31 *March v E & M H Stramare Pty Ltd* (1991) 171 CLR 506, 516 (Mason CJ), 535–6 (McHugh J). See also *Chappel v Hart* (1998) 195 CLR 232, 255 (Gummow J).
- 32 See, eg, ‘[w]here negligence is in issue, causation is essentially a question of fact ... into which considerations of policy and value judgments necessarily enter’: *March v E & M H Stramare Pty Ltd* (1991) 171 CLR 506, 524 (Toohey J). See also at 515–16 (Mason CJ), 522 (Deane J); Steven Yannoulidis, ‘Causation in the Law of Negligence’ (2001) 27 *Monash University Law Review* 319.

causative factors which [were] determinative of liability', was therefore influenced by 'considerations of legal policy',³³ influenced by community values,³⁴ and distinguished from judicial or personal whim.³⁵ As a result, in some situations, it was possible for 'the applicable legal framework' to require 'a finding that no causal connection exist[ed] for legal purposes even though a physical connection exist[ed] between the thing complained of and the damage'.³⁶

By comparison, under the *Civil Liability Act 2002* (NSW), whether a factor ought to be a legally significant cause in this manner falls for consideration under section 5D(1)(b).³⁷ This section requires a court to consider the appropriate 'scope of liability', or whether 'it is appropriate for the scope of the negligent person's liability to extend to the harm so caused'. This necessitates an assessment, under subsection (4), of 'whether or not and why responsibility for the harm should be imposed'. A detailed analysis of all normative issues capable of consideration as part of scope of liability, if indeed possible,³⁸ is outside the parameters of this article. Nevertheless, considerations falling under this element would include questions raised by: 'intervening and successive causes' (or novus actus interveniens);³⁹ 'foreseeability and remoteness';⁴⁰ 'the terms of any applicable statute';⁴¹ and, as discussed below,⁴² the purpose of the rule or duty of care violated. In *French v QBE Insurance (Australia) Ltd*, Fryberg J also considered that the factors relevant to determining scope of liability 'might overlap or duplicate those considered in relation to the existence of a duty', or its

33 *Allianz Australia Insurance Ltd v GSF Australia Pty Ltd* (2005) 221 CLR 568, 586–7 (McHugh J); *Travel Compensation Fund v Tambree* (2005) 224 CLR 627, 643 (Gummow and Hayne JJ).

34 *Travel Compensation Fund v Tambree* (2005) 224 CLR 627, 648 (Kirby J).

35 Ibid 650. See also *Roads and Traffic Authority v Royal* (2008) 245 ALR 653, 675 (Kirby J).

36 *Allianz Australia Insurance Ltd v GSF Australia Pty Ltd* (2005) 221 CLR 568, 586 (McHugh J). See also *Henville v Walker* (2001) 206 CLR 459, 491 (McHugh J); *Roads and Traffic Authority v Royal* (2008) 245 ALR 653, 663 (Gummow, Hayne and Heydon JJ), 687 (Kiefel J).

37 See, eg, *Strong v Woolworths Ltd* (2012) 246 CLR 182, 190–1 (French CJ, Gummow, Crennan and Bell JJ); *Adeels Palace Pty Ltd v Moubarak* (2009) 239 CLR 420. 'Dividing the issue of causation in this way expresses the relevant questions in a way that may differ from what was said by Mason CJ [in *March v E & M H Stramare Pty Ltd* (1991) 171 CLR 506] to be the common law's approach to causation': at 440 (French CJ, Gummow, Hayne, Heydon and Crennan JJ).

38 *Travel Compensation Fund v Tambree* (2005) 224 CLR 627, 648 (Kirby J).

39 *Monaghan Surveyors Pty Ltd v Stratford Glen-Avon Pty Ltd* [2012] NSWCA 94, [70] (Basten JA), [1] (McColl JA agreeing), [113] (Young JA agreeing); *Ipp Report*, above n 5, 115. See also *Roads and Traffic Authority v Royal* (2008) 245 ALR 653, 675 (Kirby J); *Travel Compensation Fund v Tambree* (2005) 224 CLR 627, 637–8 (Gleeson CJ).

40 *Monaghan Surveyors Pty Ltd v Stratford Glen-Avon Pty Ltd* [2012] NSWCA 94, [70] (Basten, JA), [1] (McColl JA agreeing), [113] (Young JA agreeing); *Ipp Report*, above n 5, 117.

41 *Travel Compensation Fund v Tambree* (2005) 224 CLR 627, 648 (Kirby J); *Neville v Lam [No 3]* [2014] NSWSC 607, [195] (Beech-Jones J), discussed below n 136.

42 See especially below nn 104–36 and accompanying text; below Parts IV(A)(2), IV(B), V.

breach, and included within these the notion of '[p]roximity (or lack of it) in time, place and relationship'.⁴³

Both elements of causation are discussed further below, in the context of the factual circumstances of *Wallace*. At this stage however it is important to note that, although the subject of both academic⁴⁴ and judicial⁴⁵ criticism, the bifurcation of causation into factual and normative issues effected by sections 5D(1)(a) and (b) was upheld.⁴⁶ While an exception to this bifurcation may be found in section 5D(2),⁴⁷ as it was not in issue in *Wallace*, this provision is not

43 (2011) 58 MVR 214, 250. See also *Zanner v Zanner* (2010) 79 NSWLR 702, 706 (Allsop P) (the 'attenuated standard of care' owed by the defendant was considered to inform the appropriate scope of liability under ss 5D(1)(b) and (4) of the *Civil Liability Act 2002* (NSW)). For further factors relevant at common law that may also apply to scope of liability under the civil liability legislation, see generally Stapleton, above n 24, 411 ff; *Harvey v PD* (2004) 59 NSWLR 639, 660–6 (Santow JA).

44 See, eg, David Hamer, "'Factual Causation' and 'Scope of Liability': What's the Difference?" (2014) 77 *Modern Law Review* 155.

45 See, eg, *Harvey v PD* (2004) 59 NSWLR 639, 643 (Spigelman CJ); *Travel Compensation Fund v Tambree* (2005) 224 CLR 627, 643 (Gummow and Hayne JJ) (The specific consideration of whether a defendant ought to be liable to pay damages for harm was argued to be inconsistent with the rejection, by *Sullivan v Moody* (2001) 207 CLR 562, of the test from *Caparo Industries Plc v Dickman* [1990] 2 AC 605. This test incorporates notions of what is fair, just and reasonable into the resolution of whether a duty of care is owed in negligence.). See also *Travel Compensation Fund v Tambree* (2005) 224 CLR 627, 653–4 (Callinan J); cf at 647–50 (Kirby J).

46 See discussion below nn 80–82, 98–103 and accompanying text.

47 See above n 25. Section 5D(2) of the *Civil Liability Act 2002* (NSW) provides that:

In determining in an exceptional case, in accordance with established principles, whether negligence that cannot be established as a necessary condition of the occurrence of harm should be accepted as establishing factual causation, the court is to consider (amongst other relevant things) whether or not and why responsibility for the harm should be imposed on the negligent party.

As such, where the 'but for' test is not satisfied, sub-s (2) arguably allows, in applying other 'established principles', for a consideration of normative issues when deciding factual causation: see, eg, *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 044–45 [4] (Allsop P), 66 069 [163] (Basten JA); *Strong v Woolworths Ltd* (2012) 246 CLR 182, 194 (French CJ, Gummow, Crennan and Bell JJ). See also *Adeels Palace Pty Ltd v Moubarak* (2009) 239 CLR 420, 443 (French CJ, Gummow, Hayne, Heydon and Crennan JJ).

considered further here.⁴⁸ Furthermore, it was the second element – concerning the scope of Dr Kam’s liability – upon which the case ultimately failed. In the next part we provide an outline of the reasoning in this regard, as decided by each of the courts as the matter progressed on appeal.

III THE DECISION IN *WALLACE V KAM*: ITS PROCEDURAL HISTORY AND THE REASONING ADOPTED AT EACH STAGE

The claimant in *Wallace* had a history of back pain caused by an intervertebral disc protrusion in the lumbar spine due to heavy lifting at work. Over time, Mr Wallace’s back problems worsened and, in 2004, he was referred to a neurosurgeon, Dr Kam. After an unsuccessful attempt to manage the pain through weight loss, Kam performed lumbar fusion surgery (‘the procedure’) which carried with it two inherent risks that were of relevance to Wallace’s claim. The first was a risk of bilateral femoral neurapraxia – a form of temporary local nerve damage to the anterior femoral, or thigh, region of the leg, stemming from the fact that the surgery required the patient to lie prone for an extended period of time. The second, more serious, risk was a one-in-twenty chance of permanent and catastrophic paralysis, or spinal nerve damage. Although this latter risk did not eventuate in the circumstances of the case, Kam warned Wallace of neither risk prior to the procedure taking place.⁴⁹

The day after the procedure, Wallace experienced extreme pain and paralysis in both legs. These issues persisted after further surgery and resulted in a

48 Although waiting further determination by the High Court, it is commonly assumed that instances falling within s 5D(2) of the *Civil Liability Act 2002* (NSW) would include those similar to *McGhee v National Coal Board* [1972] 3 All ER 1008, *Bonnington Castings v Wardlaw* [1956] AC 613, and *Fairchild v Glenhaven Funeral Services Ltd* [2002] 3 All ER 305. In these cases, two or more separate factors, or breaches, operated either individually or cumulatively in such a way that neither medicine nor science could determine their relative contribution to the particular harm claimed in a way that satisfied the ‘but for’ test. Nevertheless, a sufficient causal connection was established by showing that the defendant’s wrongful act or omission had instead materially increased the risk of the harm occurring: see, eg, *Ipp Report*, above n 5, 109–11. Because *Wallace* classified a medical practitioner’s duty to warn as a single comprehensive duty, in a case involving a failure to disclose a procedure’s multiple material risks, it requires factual causation to be determined on the basis of the entirety of a defendant’s solitary breach by considering what a patient would have done had *all* risks been disclosed: see below nn 152–5 and accompanying text. Consequently, as the non-disclosure of multiple risks by one defendant does not operate as a separate breach of duty (or warrant a separate consideration of factual causation) for each risk, it is submitted that on the basis of previous authority, even if the relative contribution of each risk’s non-disclosure to the occurrence of a patient’s harm (or decision to have a procedure) could not be shown, it is unlikely that a failure to establish factual causation under s 5D(1)(a) in *Wallace* would have attracted the operation of s 5D(2). Furthermore, if sub-s (2) did apply, it is likely that the normative considerations discussed below in Parts IV(A) and (B) would still operate to deny causation under it. See, eg, *Adeels Palace Pty Ltd v Moubarak* (2009) 239 CLR 420, 443–4 (French CJ, Gummow, Hayne, Heydon and Crennan JJ).

49 *Wallace v Kam* (2013) 250 CLR 375, 379–80, 387 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

diagnosis of bilateral femoral neurapraxia. It was not claimed that Wallace's neurapraxia was caused by Kam's negligent or substandard performance of the procedure itself.⁵⁰ Instead, the case was argued solely on the basis that the medical practitioner's negligent non-disclosure of both risks had caused the patient's injury.⁵¹

Initially, the case may appear similar to many other negligence actions concerning a failure to warn of surgical risks. As mentioned above,⁵² it in fact presented a unique normative issue. Had a warning concerning the risk of neurapraxia (the harm which did eventuate) been provided by Kam, it was considered that Wallace would have been willing to run that risk.⁵³ However, it was argued that had Kam warned of the more serious risk of paralysis, in addition to the risk of neurapraxia, Wallace would have declined the procedure and avoided the neurapraxia as a consequence.⁵⁴ The case therefore raised the difficult question of whether a doctor should be liable for an injury that a patient may be willing to accept, but would have avoided had the warning included information concerning a different material risk.

A The Decision at First Instance

At trial in the New South Wales Supreme Court,⁵⁵ Harrison J considered that, as Wallace had already been 'housebound and bedridden due to a combination of back pain and obesity for many weeks', the possibility of 'further, even if only but not necessarily temporary or transitory, interference with his mobility' would be significant to both a reasonable, and the particular, patient.⁵⁶ Accordingly, Kam was held to have breached both the proactive and reactive limbs⁵⁷ of his duty to warn by failing to advise Wallace of the material risk of neurapraxia.⁵⁸ Despite this conclusion, no finding was made concerning the failure to warn of the risk of paralysis⁵⁹ because, according to his Honour, 'the legal cause of [a]

50 *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518, [1].

51 *Ibid.*

52 See above nn 12–16 and accompanying text.

53 *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518, [91], affd *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 048 [20]; *Wallace v Kam* (2013) 250 CLR 375, 379.

54 *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518, [95]; *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 051 [39], 66 054 [65] (Beazley JA), 66 068 [157] (Basten JA); *Wallace v Kam* (2013) 250 CLR 375, 379–80, 387 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

55 *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518.

56 *Ibid* [49].

57 See above n 5 and accompanying text.

58 *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518, [48]–[51].

59 However, on appeal, Beazley JA considered that '[a] reasonable person, contemplating operative treatment to resolve a condition that was not life threatening and potentially not urgent, may well attach significance to a 5 per cent risk of a catastrophic outcome in making a decision as to whether or not to undergo surgery': *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 054 [67]. See also at 66 052 [49], 66 065 [136], 66 067 [152] (Beazley JA).

condition’ – here neurapraxia – ‘could never be the failure to warn of some other risk that did not materialise’.⁶⁰

Justice Harrison consequently addressed the risk of neurapraxia separately, and concluded that Wallace’s claim should not succeed due to an inability to prove factual causation under section 5D(1)(a) of the *Civil Liability Act 2002* (NSW).⁶¹ It was determined that Kam’s breach was not a necessary condition of the occurrence of the harm because ‘having regard to his desperate preoperative plight’,⁶² if warned of the risk of neurapraxia alone, Wallace would have not have refused or delayed the procedure. On this basis, no further findings were made on the issue of causation. Notably, Harrison J did not acknowledge the significance of the risk of paralysis being disclosed in conjunction with the risk of neurapraxia. His Honour’s judgment also failed to consider the scope of liability issues relevant to the second element of establishing causation, for either of the two risks.

B The New South Wales Court of Appeal

Wallace also failed on the causation issue in the Court of Appeal. Nevertheless, the reasoning there differed significantly to that at first instance.

As it was not decided at trial, the decisions on appeal assumed that the risk of paralysis in *Wallace* was material and that, if warned of it, the claimant would not have undergone the procedure.⁶³ Accordingly, on the premise that patients are

60 *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518, [96].

61 *Ibid* [70]–[71], [91]–[94].

62 *Ibid* [94]. Justice Harrison considered the circumstances such that ‘[t]he prospect for this plaintiff of some mild and temporary interference with power and sensation in his lower limbs [in the form of bilateral femoral neurapraxia, would be] ... out of all proportion to the disabling and distressing condition from which he hoped Dr Kam’s surgery would provide a cure or at least some relief’. See also *Wallace v Kam* (2013) 250 CLR 375, 379 (French CJ, Crennan, Kiefel, Gageler and Keane JJ); *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 048–49 [20] (Allsop P).

63 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 046 [11], 66 049 [22] (Allsop P), 66 054–55 [67]–[69], 66 067 [152]–[153] (Beazley JA), 66 068 [156]–[157], 66 071 [174] (Basten JA); *Wallace v Kam* (2013) 250 CLR 375, 380 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). Accordingly, as noted previously at above n 12–13 and accompanying text, whether the risks were material was not an issue on appeal in *Wallace*. Justice of Appeal Beazley further noted that although it was ‘not appropriate for the Court to engage in a fact finding task of this nature’, Wallace’s submission (that had both risks been known, he would have declined the procedure) was supported by ‘his weight being more than he believed ... the scope for more weight loss before the surgery was finally decided upon ... a misapprehension that the back surgery was necessary at that time; that the surgery was not urgent’ and that the ‘reason for recommending it at that time was the appellant’s loss of quality of life’: *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 055 [68], 66 067 [153]. In *Wallace*, prior to the procedure, the patient had tried to manage his pain through weight loss and believed that although he had lost weight the pain had worsened. Unknown to him, his scales were inaccurate and he had actually gained weight: see, in the High Court of Australia, Ian Wallace, ‘Appellant’s Amended Submissions’, Submission in *Wallace v Kam*, S307/2012, 1 November 2012, [17]–[18], [21].

entitled to make decisions ‘on the basis of complete information’,⁶⁴ the Court of Appeal (Allsop P, Beazley and Basten JJA)⁶⁵ accepted that factual causation could potentially be established because, on the facts assumed, had he known of all risks – particularly the risk of paralysis⁶⁶ – Wallace would have avoided injury. However, Wallace was again unsuccessful as Allsop P and Basten JA held that responsibility for the harm suffered should not extend to Kam.⁶⁷ In this respect, that Wallace was willing to run the risk of neurapraxia in isolation was particularly significant, and according to Basten JA, made the imposition of liability contrived:

Once the trial judge was not persuaded that a warning as to bilateral femoral neurapraxia would have led to a postponement of the operation, why should the practitioner bear responsibility for breach of a separate duty to warn of a risk which did not materialise? Recovery in such circumstances appears opportunistic.⁶⁸

President Allsop similarly precluded recovery for neurapraxia pursuant to sections 5D(1)(b) and (4) of the *Civil Liability Act 2002* (NSW), by limiting the scope of a practitioner’s duty of disclosure to protecting patients ‘from harm from material inherent risks that are unacceptable’ to them.⁶⁹

64 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [14] (Allsop P). See also at 66 045 [8] (Allsop P).

65 *Ibid* 66 047 [14] (Allsop P), 66 065–6 [138], 66 066 [143] (Beazley JA). In relation to Basten JA, although stating that ‘[t]he causal relationship would be established by a finding (yet to be made) that, if warned of the potentially catastrophic risk [of paralysis], the appellant would not have undergone the procedure’: at 66 071 [174], it should be noted that his Honour does not appear entirely convinced that factual causation could be established in *Wallace*. Firstly, Justice of Appeal Basten’s conclusion under s 5D(1)(a) of the *Civil Liability Act 2002* (NSW) is expressed as potentially contingent upon the policy considerations discussed below n 68 and accompanying text: *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 071–2 [175]. Secondly, as reflected in those considerations, his Honour seems to endorse the trial judge’s decision on factual causation by viewing the duty to warn in the case of multiple risks as requiring a distinct duty, and therefore a separate consideration of factual causation for each risk: at 66 068–89 [161], 66 070 [169]–[170], 66 071 [173], 66 072 [180]. By comparison, Allsop P and Beazley JA both considered Kam’s duty to warn to be a single comprehensive duty covering all material risks and this directed their Honours’ approaches and conclusions regarding factual causation: at 66 045 [8] (Allsop P), 66 054 [62], 66 061 [110]–[111], 66 066 [143] (Beazley JA). Nevertheless, in the event that Justice of Appeal Basten’s reasoning was incorrect in these respects, particularly ‘as to whether s 5D demands a rigid separation of physical and policy considerations in assessing causation’, his Honour was willing to accept the position put forward by Allsop P, and on either approach would have still denied liability on the facts: at 66 072 [181].

66 [2012] Aust Torts Reports ¶82–101, 66 051 [39].

67 *Ibid* 66 045–50 [10]–[32] (Allsop P), 66 071–72 [173]–[175] (Basten JA).

68 *Ibid* 66 071 [173]. See also at 66 047 [16] (Allsop P).

69 *Ibid* 66 047 [14]. President Allsop further stated:

It is undoubted that the duty is a single comprehensive duty, but the harm for which the doctor should be held liable is the just and appropriate consequences of his or her breach of failing to warn of inherent risks. That, however, should not extend to harm from risks that the patient was willing to hazard, whether through an express choice or as found had their disclosure been made. This limits recovery to what was an unacceptable risk (or risks) and harm therefrom that has (or have) not been the subject of a warning: at 66 048 [19].

Justice of Appeal Beazley's dissent on scope of liability was also grounded in an analysis of how causation principles should be coherent with the scope and content of the duty of care.⁷⁰ According to her Honour, the purpose of the duty to warn of material risks was to enable patients to make fully informed decisions concerning the risk of surgery, and Wallace was deprived of this opportunity as a result of Kam's failure to warn of *both* material risks. Consequently, by focusing upon an *overall risk of treatment* that was unacceptable to a patient (due to their lack of knowledge of one or more material risks), rather than upon the exposure of patients to an unacceptable *risk of the particular physical harm* that occurred, Justice of Appeal Beazley's view of the duty's purpose was ultimately wider than that of Allsop P⁷¹ and the High Court.⁷² Her Honour stated that:

where there is more than one material risk, and a finding is made that a plaintiff would not have undergone surgery if warned of other material risks, it is difficult to see reasons in logic or policy why a negligent doctor should not be liable notwithstanding that a different risk eventuated.⁷³

Therefore, assuming Wallace would not have had the procedure if also warned of the paralysis risk, Beazley JA judged it 'appropriate that the scope of the defendant's liability extend to the harm in fact caused'.⁷⁴

C The High Court

The decision of the majority of the Court of Appeal was affirmed by a unanimous High Court judgment (French CJ, Crennan, Kiefel, Gageler, and Keane JJ). Similarly to Justice of Appeal Beazley's dissent, the Court noted that the duty in question protected a patient's right to decide whether or not to undergo treatment and that 'the common law recognis[ed] not only the right of the patient to choose but the need for the patient to be adequately informed in order to be able to make that choice rationally'.⁷⁵ Nevertheless, this statement was accompanied by a caveat. The Court recognised that the elements of duty and causation are intended to serve different functions, 'the former imposing a forward-looking rule of conduct; the latter imposing a backward-looking attribution of responsibility for breach of the rule'.⁷⁶ The Court, unlike Beazley JA, considered that, although it may appear to uphold the performance of

70 Ibid 66 066–7 [144]–[151].

71 Ibid 66 047 [17].

72 See below nn 86–9 and accompanying text.

73 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 067 [148] (Beazley JA). Her Honour did however recognise that it may be inappropriate 'for the scope of the defendant's negligent failure to warn of [a] risk to extend to ... different harm' where that 'risk, although material, has relatively minor consequences': at 66 067 [149].

74 Ibid 66 067 [150]. In doing so, her Honour adopts statements made in *Chappel v Hart* (1998) 195 CLR 232, 238 (Gaudron J), 256–7 (Gummow J) and *Rosenberg v Percival* (2001) 205 CLR 434, 461 (Gummow J): *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 067 [147].

75 *Wallace v Kam* (2013) 250 CLR 375, 380.

76 Ibid 387.

a medical practitioner's duty to warn,⁷⁷ it is 'not necessarily appropriate' to attribute every form of physical injury suffered by a patient to a doctor's breach, simply because factual causation can be established.⁷⁸ Rather, 'policy considerations that inform the imposition of a particular duty ... may operate to deny liability for particular harm that is caused by a particular breach of that duty'.⁷⁹

In addressing causation under the statutory test provided by section 5D of the *Civil Liability Act 2002* (NSW), the High Court emphasised that, although typically overlooked in previous common law decisions where policy considerations and value judgments have been made and considered when deciding causation as an issue of fact,⁸⁰ the element of factual causation is now considered separately from such normative aspects of causation, which instead fall for consideration under scope of liability.⁸¹ As such, in examining factual causation in the circumstances of *Wallace*, the High Court confirmed that a determination 'in accordance with [section] 5D(1)(a) involves nothing more or less than the application of a "but for" test',⁸² which will be established whenever a patient can demonstrate, on the balance of probabilities, that they have 'sustained, as a consequence of having chosen to undergo the medical treatment, physical injury which the patient would not have sustained if warned of *all* material risks'.⁸³ Similarly to the Court of Appeal, the High Court therefore concluded that factual causation could be established on the assumption that 'but for' Kam's failure to disclose all risks, the claimant would not have undergone the procedure at all and would not have then sustained neurapraxia.⁸⁴

Turning then to the normative considerations required by scope of liability and the issue of whether or not liability for the neurapraxia should be imposed on Kam, the High Court was persuaded by the argument that Wallace should not be compensated for acceptable risks.⁸⁵ Influenced by the reasoning of

77 Ibid. French CJ, Crennan, Kiefel, Gageler and Keane JJ further stated:

[T]he policy of the law in imposing the duty on the negligent party will ordinarily be furthered by holding the negligent party liable for all harm that occurs in fact ... if the harm was of a kind the risk of which it was the duty of the negligent party to use reasonable care and skill to avoid: at 386.

78 Ibid 387. See also *Paul v Cooke* (2013) 85 NSWLR 167, 189, 194 (Leeming JA), 172 (Ward JA agreeing). The 'policy' argument that 'negligent medical practitioners should be liable for harm which is causally connected with their breach ... ignores the subtractive effect of s 5D(1)(b) and of the previous doctrines developed by the law to constrain the limits of liability for negligence which inform its operation': at 194 (Leeming JA).

79 *Wallace v Kam* (2013) 250 CLR 375, 387 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

80 Ibid 381. See further above nn 30–6 and accompanying text.

81 Ibid 383.

82 Ibid.

83 Ibid (emphasis added).

84 Ibid 379–80, 387.

85 Ibid 388.

Allsop P,⁸⁶ the Court held that the policy of the law was not to protect the patient's *right* to choose in a general sense,⁸⁷ nor was it to protect the patient from *exposure* to undisclosed risks.⁸⁸ The Court instead held that the purpose of the duty to warn was to 'enable the patient ... "to avoid the occurrence of ... particular physical injury the risk of which [the] patient [was] not prepared to accept"'.⁸⁹ Based on this reasoning, it was concluded that the risk of paralysis was distinct from and did not affect the risk of neurapraxia.⁹⁰ Therefore, as Wallace would have been willing to hazard the risk of neurapraxia alone (by continuing with the procedure), he did not sustain physical injury the risk of which was unacceptable to him and should not be compensated for it.⁹¹

The reasoning underpinning this determination of the case, by the High Court of Australia and the New South Wales Court of Appeal, will now be analysed more closely.

IV ANALYSIS OF THE REASONING IN WALLACE

The question of whether, upon failing to warn of multiple material risks, a medical practitioner's liability extends to an occurrence of harm the risk of which (in isolation) a patient may be willing to accept, is indeed complex. It is therefore unsurprising that *Wallace* was fundamentally decided upon the basis of policy considerations concerning the interrelation between the purpose of the duty to warn and the protection of a patient's right to decision-making autonomy. Accordingly, against a backdrop of other jurisprudence in this field, this Part commences by examining the implications of *Wallace* for a structured consideration of causation issues in future non-disclosure cases under the civil liability legislation. It then investigates the decision's impact on patient rights protection and the classification of risk, before considering whether it

86 Ibid 390. See also:

The duty and the rule of responsibility are not to protect the patient from the risk of an uninformed decision; they are not to protect the integrity of the decision ... They are to protect the patient from harm from material inherent risks that are unacceptable to him or her: *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [14] (Allsop P).

87 Discussed further below Part IV(B).

88 *Wallace v Kam* (2013) 250 CLR 375, 381. Cf *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 067 [148] (Beazley JA).

89 *Wallace v Kam* (2013) 250 CLR 375, 381 (citations omitted). 'The underlying policy is rather to protect the patient from the occurrence of physical injury the risk of which is unacceptable to the patient': at 390 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

90 Ibid 388–9 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). See also *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047–48 [17]–[18], 66 049 [21], 66 049 [26], 66 050 [30]–[31] (Allsop P), 66 070 [169], 66 071 [172] (Basten JA).

91 *Wallace v Kam* (2013) 250 CLR 375, 389–91.

corresponds with the way in which individual patients may make decisions concerning serious medical procedures.

In doing so, it seeks to highlight that the reasoning offered in *Wallace* failed to consider a potentially significant aspect of such cases. The essence of Wallace's submission was that 'all the inherent material risks of the proposed surgery were relevant to his decision-making'.⁹² Although perhaps reflective of how the case proceeded on appeal,⁹³ in our view, the majority reasoning does not, within the ambit of the appropriate scope of liability set by their Honours, sufficiently consider whether 'the total impact of the risk this man was facing in undergoing this surgery'⁹⁴ might reasonably have had a bearing upon his found willingness to chance particular physical injury in the form of the neurapraxia suffered. Their Honours only discuss that, because they were not medically cumulative, the risks required separation.⁹⁵ As such, any effect of the risk of paralysis upon Wallace's willingness to chance neurapraxia was not considered. Rather, it was to be held irrelevant to the pivotal issue of whether Wallace sustained a 'physical injury the risk of which [was] unacceptable' to him.⁹⁶ This argument is explored further below.⁹⁷

A A Causation Framework for Non-Disclosure Cases

For the purpose of the *Civil Liability Act 2002* (NSW) (and its equivalent in other jurisdictions),⁹⁸ *Wallace* confirms that a decision under section 5D(1)(a), 'that negligence was a necessary condition of the occurrence of harm' is entirely

92 Ian Wallace, 'Appellant's Amended Submissions', Submission in *Wallace v Kam*, S307/2012, 1 November 2012, [35] (emphasis added). See also *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 050, 66 051 [39] (Beazley JA), 66 068 [157] (Basten JA).

93 Because the medical practitioner's failure to warn of the risk of paralysis was considered to be causally irrelevant at trial, Harrison J did not address the significance of this risk being disclosed in conjunction with the risk of neurapraxia. Although it was assumed that knowledge of the paralysis would have precluded the procedure's occurrence, no findings were ever made as to the patient's likely response if warned of both risks: see, eg, above nn 59–63 and accompanying text; *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 046 [11], 66 049 [22] (Allsop P), 66 067 [153] (Beazley JA), 66 068 [157], 66 071 [174] (Basten JA); *Wallace v Kam* (2013) 250 CLR 375, 379–80 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

94 Ian Wallace, 'Appellant's Amended Submissions', Submission in *Wallace v Kam*, S307/2012, 1 November 2012, [38] (citations omitted).

95 See above n 90; below nn 223–7, 260 and accompanying text.

96 *Wallace v Kam* (2013) 250 CLR 375, 389–90 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). See also at 381, 390–1; *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [14], 66 047–48 [17]–[19], 66 049 [21] (Allsop P), 66 071 [172] (Basten JA).

97 See below Part IV(D).

98 See above n 25.

factual and is to be decided on a ‘but for’ basis.⁹⁹ The decision also confirms that a determination of scope of liability pursuant to sections 5D(1)(b) and (4) is ‘entirely normative’, requiring a discrete consideration of ‘whether or not, and if so why, responsibility for the harm should be imposed on the negligent party’.¹⁰⁰ This approach aligns with statements made in the statutory context in *Strong v Woolworths Ltd*,¹⁰¹ and at common law by McHugh J in *March v E & M H Stramare Pty Ltd*,¹⁰² that ‘the “but for” test should be seen as the test of legal causation’ and that ‘[a]ny other rule limiting responsibility for damage caused by a wrongful act or omission should be recognized as a policy-based rule concerned with remoteness of damage’,¹⁰³ or the extent to which a defendant ought to be liable.

Scope of liability therefore places a limit on a defendant’s accountability for harm, in circumstances where a historical factual connection¹⁰⁴ between the harm and the defendant’s negligence, or breach of duty, has already been shown to exist.¹⁰⁵ Consequently, it operates as a line drawing exercise to determine where a claimant’s recovery should cease, by requiring a court to explicitly consider if – based on notions of moral responsibility, common sense, value judgments or

99 *Wallace v Kam* (2013) 250 CLR 375, 383 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). See also *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 044–45 [3]–[4] (Allsop P). Cf Basten JA who appeared to accept the potential for factual causation, under s 5D(1)(a) of the *Civil Liability Act 2002* (NSW), to be influenced by normative judgment: see above n 65; *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 069 [163]–[164], 66 071–72 [175], 66 072 [181].

100 *Wallace v Kam* (2013) 250 CLR 375, 383 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). See also *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 044–45 [4], 66 046 [12] (Allsop P). Cf *Paul v Cooke* (2012) 85 NSWLR 167, where it was considered that:

It would be most surprising if scope of liability, which is central to establishing the limits of negligence, was confined to purely normative considerations ... There is to my mind no basis in the statute or any decision on it to support the notion that the strength of the causal connection (or any other factual matter relevant to factual causation) is irrelevant to the determination of what is ‘appropriate’: at 192 (Leeming JA).

See also at 172 (Ward JA agreeing), 172 (Basten JA).

101 (2012) 246 CLR 182, 190–1 (French CJ, Gummow, Crennan and Bell JJ). See also *Adeels Palace Pty Ltd v Moubarak* (2009) 239 CLR 420, 440, 442–3 (French CJ, Gummow, Hayne, Heydon and Crennan JJ).

102 (1991) 171 CLR 506, 534 (while in the minority on this issue, McHugh J formed part of the majority in allowing the appeal in this case). See, eg, Mason CJ, who stated that ‘[I]ike McHugh J, I would allow this appeal but my reasons for taking this course are rather different from those stated by his Honour as I do not accept that the “but for” (*causa sine qua non*) test ever was or now should become the exclusive test of causation in negligence cases’: at 508.

103 *March v E & M H Stramare Pty Ltd* (1991) 171 CLR 506, 534 (McHugh J). See also RP Balkin and J L R Davis, *Law of Torts* (LexisNexis Butterworths, 5th ed, 2013) 320.

104 Whether established under s 5D(1)(a) of the *Civil Liability Act 2002* (NSW) or exceptionally under s 5D(2): see above nn 25, 47.

105 See, eg, *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [15] (Allsop P).

policy¹⁰⁶ – liability can be justifiably imposed upon a defendant. The element reflects an ‘instinctive belief that a person should not be liable for every wrongful act or omission which is a necessary condition of the occurrence of the injury that befell the plaintiff’,¹⁰⁷ or, as stated in *Wallace* by the New South Wales Court of Appeal, a conclusion as to whether in the circumstances ‘posited liability would be “unjust”, “absurd” or “unacceptable”’.¹⁰⁸ This may arise due to the ‘tenuousness of the factual link or some limitation by reference to the rule of responsibility involved’.¹⁰⁹ For example, assume that a passenger on a speeding motorcycle is injured when the sidecar in which they are travelling is struck by lightning. In these circumstances it might be considered quite unreal to accept a conclusion, under section 5D(1)(a), that the negligent driving (assuming that it was negligent to speed) was a necessary condition of the injury due to the fact that ‘but for’ the speeding, the motorcycle would not have been on that part of the road at that point in time and would have missed the lightning strike. Rather, one might argue that such a finding should be rejected under sections 5D(1)(b) and (4) on the basis that the imposition of negligence liability for speeding is limited to only protecting persons from harm ‘arising in certain familiar ways which would normally be regarded as the risks attendant on speeding’.¹¹⁰

Importantly then, ‘[q]uestions of causation are not answered in a legal vacuum’, but are addressed in the context of ‘the legal framework in which they arise’.¹¹¹ Accordingly, given that the elements of the negligence action are

106 See, eg, *Chappel v Hart* (1998) 195 CLR 232, 243 (McHugh J); *March v E & M H Stramare Pty Ltd* (1991) 171 CLR 506, 523 (Deane J), 530–1 (McHugh J); *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 045–46 [10] (Allsop P). See also Leeming JA in *Paul v Cooke*, referring to the ‘common experience of the relevant community’: (2013) 85 NSWLR 167, 180 (citations omitted). See also at 172 (Ward JA agreeing).

107 *Chappel v Hart* (1998) 195 CLR 232, 243 (McHugh J).

108 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 046 [12] (Allsop P).

109 Ibid. See also Hayne J in *Chappel v Hart* (1998) 195 CLR 232, 283, who refers to the fact that the ‘application of a “but for” test does not identify what might be called the “quality” of the causal connection’. A weak causal connection has also been stated to be ‘far from an irrelevant consideration in determining whether it is appropriate for a defendant to be liable for the harm so caused’: *Paul v Cooke* (2013) 85 NSWLR 167, 192–3 (Leeming JA), 172 (Ward JA agreeing).

110 H L A Hart and T Honoré, *Causation in the Law* (Clarendon Press, 2nd ed, 2002) 122. In legal terms, the lightning strike, not being the very thing likely to occur as a result of the defendant’s wrongful driving, might also be termed as constituting a *novus actus interveniens*: see, eg, *Chappel v Hart* (1998) 195 CLR 232, 284 (Hayne J).

111 *Chappel v Hart* (1998) 195 CLR 232, 238 (Gaudron J).

interrelated,¹¹² it has been observed that common sense ‘answers to questions of causation will differ according to the purpose for which the question is asked’.¹¹³ In particular, ‘one cannot give a common sense answer to a question of causation for the purpose of attributing legal responsibility under some rule without knowing the purpose and scope of the rule’.¹¹⁴ Consequently, as mentioned above,¹¹⁵ although not determinative of causation,¹¹⁶ one of the normative factors falling under a consideration of ‘scope of liability’ is an examination of the content and purpose of the legal rule or duty of care violated by the defendant – that is, the legal policy underpinning it and whether this supports a finding of liability. Such an approach is consistent with that adopted to determine causation for the purpose of statutory liability, for example, under the *Motor Accidents Act 1988* (NSW).¹¹⁷ Here liability is also influenced, although perhaps more decisively,¹¹⁸ by ‘statutory subject, scope and purpose’.¹¹⁹

The relationship between duty of care and scope of liability can be demonstrated, in a non-medical context, by *Zanner v Zanner*.¹²⁰ In this case, a child was manoeuvring a car into the carport of the family home when his foot slipped off the brake and onto the accelerator, thereby propelling the vehicle

112 In a failure to warn context, see, eg, *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 067 [147] (Beazley JA), 66 069 [164] (Basten JA); *Rosenberg v Percival* (2001) 205 CLR 434, 438 (Gleeson CJ), 452, 458–9 (Gummow J), regarding the interrelation between the classification of a risk as material and causation, particularly given that the factors that influence a court’s decision as to whether a risk is material, such as its degree and severity, may also be relevant objective evidence when establishing causation and what the patient would have done had they known of that risk. See further below nn 141–51 and accompanying text. See generally *Tame v NSW* (2002) 211 CLR 317, 349 (McHugh J); *Graham Barclay Oysters Pty Ltd v Grant Ryan* (2002) 211 CLR 540, 622 (Kirby J).

113 *Environment Agency v Empress Car Co (Abertillery) Ltd* [1999] 2 AC 22, 29 (Lord Hoffman).

114 Ibid 31 (Lord Hoffman). See also *Chappel v Hart* (1998) 195 CLR 232, 256 (Gummow J), 276 (Kirby J), 285–6 (Hayne J); *Rosenberg v Percival* (2001) 205 CLR 434, 460–1 (Gummow J).

115 See above n 42 and accompanying text.

116 ‘Describing the injury as “the very kind of thing” which was the subject of the duty must not be permitted to obscure the need to prove factual causation’: *Adeels Palace Pty Ltd v Moubarak* (2009) 239 CLR 420, 442 (French CJ, Gummow, Hayne, Heydon and Crennan JJ). See also *Paul v Cooke* (2013) 85 NSWLR 167, 189, 194 (Leeming JA), 172 (Ward JA agreeing).

117 See, eg, *Allianz Australia Insurance Ltd v GSF Australia Pty Ltd* (2005) 221 CLR 568, 572, 581–90 (McHugh J), 595–8 (Gummow, Hayne and Heydon JJ), 599 (Callinan J) (concerning whether an employee’s injury was caused by a vehicle defect pursuant to ss 3(1) and 69(1) of the *Motor Accidents Act 1988* (NSW), such as to entitle their employer to an indemnity from Allianz under the Act).

118 See, eg, *Travel Compensation Fund v Tambree* (2005) 224 CLR 627, 645, 650 (Kirby J), 653 (Callinan J) (requiring a determination of whether payments from a Travel Compensation Fund, established pursuant to the *Travel Agents Act 1986* (NSW), to clients of a defaulting travel agent were recoverable under ss 42 and 68 of the *Fair Trading Act 1987* (NSW) because they amounted to damage caused by the misleading or deceptive conduct of the professionals responsible for the agent’s financial statements).

119 *Roads and Traffic Authority v Royal* (2008) 245 ALR 653, 674 (Kirby J). See also *Travel Compensation Fund v Tambree* (2005) 224 CLR 627, 639–40 (Gleeson CJ), 642–4 (Gummow and Hayne JJ), 644–5, 648, 651–2 (Kirby J).

120 (2010) 79 NSWLR 702.

forward into his mother.¹²¹ Before the New South Wales Court of Appeal, Allsop P held that for the purpose of sections 5D(1)(b) and (4) of the *Civil Liability Act 2002* (NSW):

All relevant considerations that inform the content of the appropriate scope of the negligent person's liability and responsibility point to a positive conclusion as to causation and liability here. Injury to the mother was entirely foreseeable should negligence occur ... The content of the duty and the attenuated standard of care were directed to the exercise of care to avoid injury to the mother in the very manner that occurred ... Common sense would attribute the mother's injury to the negligence of her son, as well as to her own negligence in putting herself in that position.¹²²

Recognising 'that it would be a rare case indeed where a motor vehicle case attracted some other policy consideration',¹²³ Tobias JA further accepted 'that dangerous, potentially lethal machines such as motor vehicles must be driven with due care and attention. If they are not ... there was every reason as a matter of policy why [the driver] should be held responsible for the harm'.¹²⁴ Relevant to the duty of care owed by medical practitioners, in *Freidin v St Laurent* an appellant obstetrician and gynaecologist argued that even if there was a 'physical connection' between his failure to perform an episiotomy and the mother's injuries, 'there was no legal causal connection' because 'the rationale behind the duty to perform an episiotomy was primarily to protect the baby'.¹²⁵ Rejecting this argument at common law, Chernov JA held that 'the rationale for the duty of care that the appellant owed the respondent was not so narrow or unrelated to the injury as to be disregarded for the purpose of determining causation'.¹²⁶ Rather, 'the appellant owed the respondent a duty of care that was wide enough to include the duty to take all reasonable steps to preserve her health and wellbeing during the delivery procedure'.¹²⁷ In *Tabet v Gett*, Kiefel J also acknowledged that it is necessary 'to understand the purpose for making an inquiry about causation' and that this 'may require value judgments and policy choices' to be made.¹²⁸

Accordingly, by applying this framework to their causation analysis in *Wallace*, neither the High Court nor the Court of Appeal¹²⁹ can be criticised, in general terms, for adopting a surprising or unorthodox approach to considering

121 Ibid 707.

122 Ibid 706.

123 Ibid 719 (Tobias JA). Eg, 'where the relevant harm is only remotely connected to the defendant's conduct'.

124 Ibid 717.

125 (2007) 17 VR 439, 451 (Chernov JA), 440 (Callaway JA agreeing), 441 (Buchanan JA agreeing).

126 Ibid 451.

127 Ibid 452 (Chernov JA).

128 (2010) 240 CLR 537, 578 (in the context of determining causation on the basis of the loss of a chance of a better medical outcome and whether the common law should recognise such loss as damage for the purpose of a negligence action arising from patient mismanagement).

129 See above nn 69–79, 85–91 and accompanying text.

the specific issue of whether a medical practitioner, consistent with the purpose of their duty, *ought* to be liable for failing to warn of multiple material risks where the risk that came home was one which, in isolation, the patient would have accepted. Indeed, the Courts' scope of liability methodology under section 5D of the *Civil Liability Act 2002* (NSW) has subsequently been applied in the area of negligent diagnosis by *Paul v Cooke*.¹³⁰ There, in confining the purpose of that aspect of a medical practitioner's duty of care to protection against 'harm that can [only] be avoided or alleviated by prompt diagnosis' or treatment,¹³¹ a radiologist's failure to detect an aneurysm was held not to have caused the claimant's disabilities when it ruptured intra-operatively following diagnosis three years later. This was because irrespective of the timing or type of operation inevitably required, the rupture risk was the same.¹³² *Wallace* was again applied in *Neville v Lam [No 3]* in the context of a wrongful birth claim arising from a practitioner's failure to advise of the potential for pregnancy following endometrial ablation.¹³³ Here, the New South Wales Supreme Court held that, had breach been established,¹³⁴ the content or purpose of the duty to advise was to prevent pregnancy, or the financial costs incurred as a result.¹³⁵ Consequently, this would have supported a finding that the practitioner's scope of liability 'ordinarily' extends to the costs incurred by the patient in raising their congenitally disabled child.¹³⁶

Of perhaps more importance then, are the implications of *Wallace's* analysis for a structured consideration of causation issues in future non-disclosure cases, regardless of the number of risks involved. This is now considered in accordance with each stage, or element, of the causation inquiry.

130 (2013) 85 NSWLR 167. In terms of methodology, Leeming JA stated that 'in *Wallace v Kam* ... the High Court has confirmed the "limiting principle" that "the scope of liability normally does not extend beyond liability for the occurrence of such harm the risk of which it was the duty of the negligent party to exercise reasonable care and skill to avoid": at 191 (citations omitted), 172 (Ward JA agreeing). The High Court's statements were also affirmed in *Neville v Lam [No 3]* [2014] NSWSC 607, [175] (Beech-Jones J).

131 (2013) 85 NSWLR 167, 187 (Leeming JA), 172 (Ward JA agreeing). See also at 172 (Basten JA), 188–9 (Leeming JA), 172 (Ward JA agreeing).

132 Ibid 173, 189, 191–2, 194–5 (Leeming JA), 172 (Ward JA agreeing).

133 [2014] NSWSC 607.

134 Ibid [140]–[143] (Beech-Jones J).

135 Ibid [189]–[191] (Beech-Jones J).

136 Ibid [192]–[195] (Beech-Jones J). Although the damages awarded in such circumstances would be limited by s 71 of the *Civil Liability Act 2002* (NSW), to those additional costs associated with rearing or maintaining the child that flow from their disability, Beech-Jones J held that there was 'nothing in the section or the secondary materials concerning its enactment [to] indicate that it was meant to operate upon section 5D(1)(b) so as to only allow recovery of the additional costs of raising a child with disability in those circumstances where the relevant negligent act materially contributed to the occurrence of the disability': *Neville v Lam [No 3]* [2014] NSWSC 607, [195].

1 Failure to Warn and Factual Causation

Failure to warn cases ‘encounter difficulties of causation that do not arise in cases of, for example, a negligent physical act “causing” injury’.¹³⁷ This is because they involve the non-disclosure of material inherent risks, or significant risks, the nature, if not the degree,¹³⁸ of which are always present as an inseparable element of the treatment performed or forgone.¹³⁹ Their occurrence is not related to, or increased by, any positive act or omission in the *performance* of the treatment itself. Consequently, Cane writes that ‘[i]n this central sense of the word “cause”, failure to warn of risk does not “cause” the materialisation of the risk of which the patient ought to have been warned’. The medical practitioner’s breach of duty instead ‘creates[s] the situation in which an extraordinary sequence of events could occur’.¹⁴⁰

A consideration of factual causation in cases of non-disclosure focuses therefore upon the hypothetical question of what the particular patient would have done had a warning been given.¹⁴¹ ‘In terms of causation theory, the critical fact is whether’, on the balance of probabilities, ‘but for’ the practitioner’s failure to warn, ‘the patient would have taken action ... that would have avoided the harm suffered’.¹⁴² Whilst this must ‘be determined subjectively in the light of all relevant circumstances’,¹⁴³ under section 5D(3)(b) of the *Civil Liability Act 2002* (NSW),¹⁴⁴ any statement made by the patient, either in or out of court,¹⁴⁵ about what they would have done is inadmissible, except to the extent (if any) that such statement is against their interest. In cases involving a failure to disclose the material risks inherent in medical procedures, it is perhaps understandable that a patient suffering from an unexpected complication would be likely to state directly in the course of expensive litigation that they would not have had a procedure if they had known of its risk(s).¹⁴⁶ Given this, when determining a patient’s likely course of conduct, objective factors such as ‘the remoteness of the risk’ and the patient’s ‘need’ or ‘desire for treatment’ and the ‘alternatives

137 *Rosenberg v Percival* (2001) 205 CLR 434, 460 (Gummow J). See generally *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 071–72 [175] (Basten JA).

138 See, eg, *Chappel v Hart* (1998) 195 CLR 232, 241 (Gaudron J), discussed below n 183 and accompanying text.

139 Ibid 241 (Gaudron J). See further above n 3 and accompanying text.

140 Peter Cane, ‘A Warning about Causation’ (1999) 115 *Law Quarterly Review* 21, 22. See also *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 068 [158] (Basten JA).

141 *Rosenberg v Percival* (2001) 205 CLR 434, 462 (Gummow J).

142 Ibid 449 (McHugh J). See also *Wallace v Kam* (2013) 250 CLR 375, 383–4 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

143 *Wallace v Kam* (2013) 250 CLR 375, 383–4 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

144 See also *Civil Liability Act 2003* (Qld) s 11(3)(b); *Civil Liability Act 2002* (WA) s 5C(3)(b); *Civil Liability Act 2002* (Tas) s 13(3)(b).

145 See, eg, *KT v PLG* [2006] NSWSC 919, [42]–[44] (Simpson J) (negligently performed surgical termination of pregnancy).

146 See, eg, *Chappel v Hart* (1998) 195 CLR 232, 272 (Kirby J); *Rosenberg v Percival* (2001) 205 CLR 434, 444 (McHugh J), 462 (Gummow J), 485 (Kirby J), 501–2, 504–5 (Callinan J). See further above n 26.

available'; 'previous and later procedures undertaken'; 'degree of faith' in the medical professional; and independent knowledge,¹⁴⁷ are usually viewed as more compelling.¹⁴⁸ Nevertheless, as the exclusion of a claimant's evidence under section 5D(3) is of 'quite limited' scope,¹⁴⁹ a patient's own testimony on matters such as their general 'position, beliefs and fears'¹⁵⁰ at the time of a procedure, although in their favour, would remain admissible. Evidence of third parties, about what a particular patient would have done in the circumstances, is also not excluded by the Act, but may be given little weight.¹⁵¹

Since the common law duty of care owed by a medical practitioner to their patient is a 'single comprehensive duty',¹⁵² *Wallace* determined that factual causation has to be decided on the basis of the entirety of the defendant's breach.¹⁵³ In cases similarly involving a failure to warn of multiple risks of a *single* medical procedure, this requires a consideration of what the claimant would have done if all risks had been disclosed (not just the risk that materialised and caused their harm).¹⁵⁴ As noted by Allsop P:

The potential benefits and risks of undergoing that operation were all part of the relevant information, as a whole, which the appellant was entitled to have in order to make up his mind, after weighing all relevant information, as to whether to seek the benefits of the procedure, by hazarding such risks as it entailed. It is unrealistic to posit a coherent factual enquiry for the purposes of [section] 5D(1)(a) by only asking what would have been his decision had he only been told part of what he should have been told. The duty was one comprehensive duty. If it

147 *Elbourne v Gibbs* [2006] NSWCA 127, [81] (Basten JA), [1] (Beazley JA agreeing), citing Addison, above n 9, 184–93, affd *Harris v Bellemore* [2010] NSWSC 176, [147] (McCallum J).

148 See, eg, *Rosenberg v Percival* (2001) 205 CLR 434, 443–50 (McHugh J).

149 *Neal v Ambulance Service of NSW* [2008] Aust Torts Reports ¶81–988, 62 612 [41] (Basten JA), 62 604 [1] (Tobias JA agreeing), 62 618 [67] (Handley JJA agreeing) (alleged negligence of ambulance officers in failing to advise police that the intoxicated claimant needed hospital treatment).

150 Ibid 62 612 [42] (Basten JA). See also at 62 610–14 [34]–[49] (Basten JA).

151 See, eg, ibid 62 612 [40]; *Livingstone v Mitchell* [2007] NSWSC 1477, [46]–[47] (Walmsley AJ) (a son's evidence as to what his parents would have done in a conveyancing transaction had the defendant not breached a duty of care to ascertain whether there was an adequate contract of insurance in relation to a property, although of limited probative value, was not excluded).

152 *Wallace v Kam* (2013) 250 CLR 375, 380 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). See further *Rogers v Whitaker* (1992) 175 CLR 479, 483 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ), discussed above n 1 and accompanying text.

153 *Wallace v Kam* (2013) 250 CLR 375, 387 (French CJ, Crennan, Kiefel, Gageler and Keane JJ); *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 045 [8] (Allsop P).

154 See discussion above nn 64–6 and nn 82–84 and accompanying text. In *Ellis v Wallsend District Hospital* (1998) 17 NSWLR 553, 559, Kirby P held that the subjective test of causation required a consideration of 'whether Mrs Ellis would have undergone the operation had she been fully informed of its risks both of paralysis (remote) and failure to relieve her pain (more substantial)'. See also at 561 (Kirby P), 590 (Samuels JA), 607 (Meagher JA agreeing).

was breached, that occurred, on the appellant's case, by failing to tell him of both possible risks ...¹⁵⁵

Based on this view, it is arguable that in a case concerning the non-disclosure of material risks – where *different* or *multiple independent* medical procedures are contemplated and harm occurs – there may be some justification for considering factual causation separately in relation to each procedure.¹⁵⁶ But the situation may be otherwise where the procedures are related, such that the performance of one is contingent upon the performance of another.

Consequently, in non-disclosure cases, factual causation will be established where the patient, if warned of all material risks would *not* have proceeded with a treatment or medical procedure:¹⁵⁷

- at all, and thus would not have suffered the harm that occurred;¹⁵⁸ or
- at the same time and place, or in the same circumstances – while they may have still undergone the procedure at some later time or in different circumstances, the evidence must be such that they would not, on the balance of probabilities,¹⁵⁹ have then suffered the harm.

The latter situation covers cases like *Chappel v Hart* where it was found that, had the patient known of the risk prior to the procedure taking place, she would not have refused the surgery completely but would have postponed the procedure

155 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 045 [8]. See also at 66 045 [14] (Allsop P), 66 065–66 [138], 66 065–66 [143]–[144] (Beazley JA); *Wallace v Kam* (2013) 250 CLR 375, 383, 387 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). Cf Basten JA, who (as discussed at above n 63), appears to reject the application of the 'single comprehensive duty' notion to the issue of factual causation: *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 068–69 [161], 66 070 [169]–[170], 66 071 [173]. Instead, his Honour confines the phrase's relevance to a consideration, as occurred in *Rogers v Whitaker*, of whether the principle from *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118 (namely, that a medical practitioner is not negligent if they act according to practice accepted as proper by a responsible body of medical opinion), applies to all aspects of a medical practitioner's duty of care. Accordingly, Basten JA potentially accepts that the obligation to provide information and advice in the case of multiple risks requires a distinct duty, and therefore a separate consideration of factual causation, for each risk.

156 See, eg, *Gover v South Australia* (1986) 39 SASR 543, 563, where Cox J stated that:
different types of operation and their respective risks have to be reckoned separately. They were separate procedures, and one could have been performed without the other ... In the circumstances I do not think that it can be said that the entropion and trichiasis that resulted from the canthoplasty were caused, in the relevant sense, by the failure to warn the plaintiff of a blepharoplasty risk.

157 *Wallace v Kam* (2013) 250 CLR 375, 384 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). See also *Chappel v Hart* (1998) 195 CLR 232, 247 (McHugh J).

158 See, eg, *Rogers v Whitaker* (1992) 175 CLR 479 (failure to advise of sympathetic ophthalmia following eye surgery); *Elbourne v Gibbs* [2006] NSWCA 127 (failure to warn of the risks of scrotum swelling, chronic pain from nerve entrapment and embolism as a result of a hernia operation); *Hribar v Wells* (1995) 64 SASR 129 (failure to warn of permanent nerve damage and numbness to tongue and lips following surgery to correct a malocclusion); *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553 (non-disclosure of a risk of paralysis and failure to relieve pain following surgery).

159 See above n 28 and accompanying text.

so that it could be performed by a more experienced surgeon.¹⁶⁰ In this instance, the undisclosed risk of infection and voice damage due to oesophagus perforation, whilst material, was held to be improbable,¹⁶¹ and the causation argument founded upon the postponement of the surgery was based upon evidence that the probability of avoiding the physical harm in question was more likely than not if the procedure was delayed.¹⁶² Therefore, on a ‘but for’ test of causation, had the surgery occurred at a different time the patient would almost certainly not have suffered the injury that she did.¹⁶³ Consequently, the surgeon’s failure to advise would have been a necessary condition of the occurrence of her harm.¹⁶⁴ However, factual causation will not be established if the patient, even if warned of all material risks, would have undergone the treatment that was in fact

160 (1998) 195 CLR 232, 237 (Gaudron J), 242 (McHugh J), 267 (Kirby J), 281 (Hayne J). See also *Henderson v Low* [2001] QSC 496, [37] (Dutney J), where a failure to warn of a rare, or slight, risk of incontinence and impotence following a laminectomy was held to have caused the claimant’s harm in circumstances where, if advised, they ‘would have at least deferred surgery until other possibilities had been tried’. See also at [21], [30] (Dutney J).

161 Indeed, being less than one per cent, the risk was held to be so speculative that it did not warrant a discount in the damages awarded on account of the probability that the risk may have occurred in any event independently of the defendant’s negligence: *Chappel v Hart* (1998) 195 CLR 232, 241–2 (Gaudron J), 262–3 (Gummow J), 278 (Kirby J).

162 This argument can be distinguished from the assertion that instead of suffering physical injury, a patient is seeking compensation for the loss of a chance of a better medical outcome (or the loss of an opportunity to postpone their procedure and have it performed by a more experienced surgeon, who via their increased skill and experience may have performed the surgery with less risk of complication). Loss of chance claims were often pleaded when there was doubt as to whether a patient could establish, on the balance of probabilities, a sufficient causal connection between their actual physical harm and a practitioner’s medical negligence or risk non-disclosure. However, in *Chappel v Hart* (1998) 195 CLR 232, such claims were rejected by a majority of the High Court in the context of a practitioner’s failure to warn. Because the duty only obliged a practitioner to advise a patient of the material risks of physical injury associated with treatment, and not of other surgeons practicing in the field, the relevant damage was said to be limited to physical harm sustained in the form of the risk that was non-disclosed: at 239 (Gaudron J), 252 (McHugh J), 288–9 (Hayne J); cf 274–5, 278–9 (Kirby J). See also *Rosenberg v Percival* (2001) 205 CLR 434, 464–5 (Gummow J). Arguably, this might now be considered as a justification relevant to scope of liability: see, eg, above nn 104–36 and accompanying text. Nevertheless, more recently, in *Tabet v Gett* (2010) 240 CLR 537, the High Court concluded that, particularly in cases involving physical injury, the common law of Australia does not recognise the loss of a chance of a better outcome as damage for the purpose of a medical negligence claim: at 554, 559 (Gummow ACJ), 580, 586–7 (Kiefel J), 564 (Hayne and Bell JJ agreeing), 575 (Crennan J agreeing).

163 *Chappel v Hart* (1998) 195 CLR 232, 240 (Gaudron J), 250–1 (McHugh J), 257 (Gummow J), 267, 277 (Kirby J), 283–4 (Hayne J). See also *Rosenberg v Percival* (2001) 205 CLR 434, 465 (Gummow J).

164 The case was decided before the enactment of the civil liability legislation. See further above n 25 and accompanying text.

chosen, at the same time and place,¹⁶⁵ or in circumstances where it is more probable than not that the harm might still occur.

In *Wallace*, the finding of factual causation was assisted by the courts' assumption that a warning of the more significant paralysis risk would have resulted in surgery refusal.¹⁶⁶ Accordingly, given that the fulfilment of factual causation, or the 'but for' test, in that case was rather weak and did not answer the normative question of whether liability ought to be imposed, the 'satisfaction of legal causation'¹⁶⁷ also required a consideration of scope of liability. It was around this question that liability turned, and it is here that the decision's impact is most strongly felt.

2 Failure to Warn and Scope of Liability

As discussed above,¹⁶⁸ the conclusion of the High Court and the Court of Appeal in *Wallace* was ultimately based upon findings as to the extent to which the practitioner ought to be liable having regard to the purpose or policy behind the legal duty violated.¹⁶⁹ The object of the duty to warn of risks inherent in undergoing or forgoing surgery or other interventions was stated as being to guard against 'the occurrence of *physical injury the risk of which [was] unacceptable to the patient*'.¹⁷⁰ It was stated that although the duty protects patients by holding medical practitioners 'responsible for the harm that may result from material inherent risks that were not the subject of warning',¹⁷¹ it does not (even if factual causation is established) 'extend to harm from risks that the patient was willing to hazard, whether through an express choice or as found had their disclosure been made'.¹⁷² Moreover, as discussed below,¹⁷³ the courts' findings concerning the scope of Dr Kam's liability were greatly influenced by the view that both non-disclosed risks were separate and distinct – the assumption being that the risks would have been evaluated independently by the patient.

165 See, eg, *Rosenberg v Percival* (2001) 205 CLR 434 (failure to warn of a risk of temporomandibular joint complications after the performance of a sagittal split osteotomy); *Harris v Bellemore* [2010] NSWSC 176 (failure to advise of the risk of joint stiffness and loss of knee flexibility following the Ilizarov technique of limb lengthening), where factual causation was not established as according to objective evidence the patient would have proceeded with the surgery at the same time and place such that their harm would have still then occurred.

166 See above nn 63–6, 84 and accompanying text.

167 *Wallace v Kam* (2013) 250 CLR 375, 385 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

168 See above nn 69–79, 85–91 and accompanying text.

169 Indeed, even Justice of Appeal Beazley's dissent in the Court of Appeal was based upon the duty's purpose, albeit a wider view of it.

170 *Wallace v Kam* (2013) 250 CLR 375, 390 (French CJ, Crennan, Kiefel, Gageler and Keane JJ) (emphasis added). See also at 381.

171 *Wallace v Kam* [2012] Aus Torts Reports ¶82–101, 66 047 [14] (Allsop P).

172 Ibid 66 048 [19] (Allsop P).

173 See below nn 223–30 and accompanying text.

For the purpose of scope of liability and the demarcation of a practitioner's legal responsibility, the policy underlying the duty to warn prescribed by *Wallace* therefore requires both a correlation between the physical injury claimed and the treatment's inherent non-disclosed risk of harm; and the patient's non-acceptance of that risk. This has significant explanatory power. First, in terms of the correlation required, as the unknown material risk must have eventuated and 'be related in a physical sense to the injury that was suffered',¹⁷⁴ Kam could not be liable solely on the basis of exposing Wallace 'to an unacceptable risk of catastrophic paralysis'¹⁷⁵ as this harm did not ensue. Importantly, this rationale also explains why damages are limited 'to sequelae which are related directly' to the material risk of which the practitioner should have warned,¹⁷⁶ and why liability is not found for other detriments consequent upon a procedure but unrelated to that risk. For example, in the commonly cited situation of physical injury in the form of lightning strike,¹⁷⁷ or misapplied anaesthetic¹⁷⁸ in an operation that would not have occurred had the patient been advised of its risks, despite factual causation being established, the surgeon will not be liable because the physical injury arising is beyond that which, in furtherance of the duty to warn of risks inherent in the surgery performed, the practitioner is required to disclose.¹⁷⁹ Even when the required correlation between harm and non-disclosed risk is present, it may be insufficient to impose liability. For example, in *Chappel v Hart*, in the context of a failure to warn of damage to the laryngeal nerve, Hayne J stated that:

174 *Rosenberg v Percival* (2001) 205 CLR 434, 460 (Gummow J), affd *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 059 [95] (Beazley JA), 66 070 [165]–[166] (Basten JA). See also *Elbourne v Gibbs* [2006] NSWCA 127, [65] (Basten JA), [1] (Beazley JA agreeing); 'For particular physical injury sustained by a patient as a result of medical treatment the patient has chosen to have carried out to be compensable, it must be determined to have been caused by the particular failure of the medical practitioner': *Wallace v Kam* (2013) 250 CLR 375, 381 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

175 *Wallace v Kam* (2013) 250 CLR 375, 390 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

176 See, eg, *Hribar v Wells* (1995) 64 SASR 129, 147 (Duggan J). See also at 130 (King CJ); cf 143–6 (Bollen J).

177 See, eg, *Chappel v Hart* (1998) 195 CLR 232, 285 (Hayne J).

178 See, eg, *ibid* 257 (Gummow J); *Rosenberg v Percival* (2001) 205 CLR 434, 460 (Gummow J); *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 046 [12] (Allsop P).

179 See, eg, *Wallace v Kam* (2013) 250 CLR 375, 385–6 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). See also above n 110 and accompanying text. In the context of misapplied anaesthetic, this conclusion is reached on the basis that it is itself separate from the surgical procedure and not a material or inherent risk of it; is such an obvious and general procedural risk that it is already known; or, being immaterial to the patient's decision, does not require disclosure: see A R Braun, L Skene and A F Merry, 'Informed Consent for Anaesthesia in Australia and New Zealand' (2010) 38 *Anaesthesia and Intensive Care* 809, 810; *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 879, 889 (Lord Scarman), 891 (Lord Diplock), 897 (Lord Bridge) 895 (Lord Keith agreeing). Statute in some jurisdictions does however preserve a professional's duty to warn of obvious risks: *Civil Liability Act* 2002 (NSW) s 5H(2); *Civil Liability Act* 2003 (Qld) s 15(2); *Civil Liability Act* 1936 (SA) s 38(2); *Civil Liability Act* 2002 (WA) s 50(2); *Civil Liability Act* 2002 (Tas) s 17(2).

If it were enough, it would follow that if the operating theatre had been struck by lightning and the respondent had suffered damage to the laryngeal nerve (because of the resulting power surge affecting the diathermy equipment being used in the operation) the appellant would be liable but that he would not if the power surge caused burns to her body.¹⁸⁰

In these circumstances, the event is not the very risk, or a normal incident of it, against which there was the duty to warn or safeguard the patient. The very risk was the risk of laryngeal nerve damage inherent in the medical procedure, not that same risk inherent in an act of God. In reality, such a strike would be said to preclude a practitioner's liability, irrespective of the injury caused, on normative grounds¹⁸¹ under sections 5D(1)(b) and (4) of the *Civil Liability Act 2002* (NSW) – specifically, on the basis of it being a novus actus interveniens, or an intervening or successive cause that is not the very thing likely to occur as a result of the defendant's wrongful failure to advise.¹⁸²

Secondly, in terms of its requirement that patients be exposed to a particular physical harm, the risk of which is unacceptable to them, *Wallace* justifies the imposition of liability in circumstances like *Chappel v Hart*. In that case, although the *nature* of the risk in question (oesophagus perforation and consequent infection) was the same no matter when, where or by whom the surgery was performed, the *degree* of risk was considered, on the balance of probabilities, to diminish 'with the skill and experience of the surgeon concerned'.¹⁸³ Although it was inevitable that the patient would need to have the procedure and accept the chance of harm at some point, it was also found that, had the risk been known, the patient would have consulted a more experienced practitioner.¹⁸⁴ Accordingly, the non-disclosure, by precluding the opportunity for the surgery to be delayed, arguably still exposed the patient to a risk of perforation and infection that was unacceptable. Similarly, in *Shead v Hooley*,¹⁸⁵ liability for the failure to warn of a potential for gastroparesis was supported by a finding that 'if Ms Hooley had sought a second opinion, the risks would have been reduced, if only because there would have been a later gastroscopy

180 *Chappel v Hart* (1998) 195 CLR 232, 285.

181 See above nn 37–43 and accompanying text.

182 *Chappel v Hart* (1998) 195 CLR 232, 284 (Hayne J). See also *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 046 [13] (Allsop P); *Ipp Report*, above n 5, 115.

183 *Chappel v Hart* (1998) 195 CLR 232, 241 (Gaudron J). See also at 239–40 (Gaudron J), 277–8 (Kirby J). However, Gummow J considered that '[t]o make good her case and to obtain the award of damages she recovered, Mrs Hart was not required to negative the proposition that any later treatment would have been attended with the same or a greater degree of risk': at 260. The dissenting judgments of McHugh and Hayne JJ held that later performance of the surgery by another would not have decreased the risk, rather the patient had only been subjected to 'a class of risk' that she would have been exposed to anyway: at 245 (McHugh J). See also at 244–6, 250 (McHugh J), 287, 289–90 (Hayne J).

184 *Ibid* 237 (Gaudron J), 242 (McHugh J), 267 (Kirby J), 281 (Hayne J).

185 [2000] NSWCA 362.

which would or may have shown that the chronic ulcer was healing'.¹⁸⁶ Indeed, jurisprudence appears to accept 'that, if the operation would have taken place [at a later time] and the risks been essentially the same, the plaintiff would have failed to establish that the harm was caused by the breach of duty'.¹⁸⁷ However, in *Chappel v Hart*, Kirby J did consider that in the absence of 'statistical or other evidence', diminished risk could be implied by 'intuition and commonsense'.¹⁸⁸ While no specific finding of a reduction of risk was made in *Reid v Basson*, a non-disclosed risk of nerve damage following lymph gland removal surgery was held causative of the patient's loss because, had the risk been known, they would not have had the procedure at the hands of a doctor in Barcaldine but at a major Brisbane hospital.¹⁸⁹

Once normative or policy choices are made under sections 5D(1)(b) and (4) for a particular category of case, they must be maintained by the courts 'unless confronted and overruled'.¹⁹⁰ Accordingly, as it has been claimed that *Wallace*'s scope of liability findings suggest a narrowing of the legal duty's purpose or its protection of patient rights,¹⁹¹ in the context of actions concerning a practitioner's failure to warn, it is important to consider this idea further.

B Patient Rights and Autonomy: A Change in Policy?

In *Rogers v Whitaker*, the High Court confirmed that 'the "duty to warn" arises from the patient's right to know of material risks, a right which in turn arises from the patient's right to decide for himself or herself whether or not to submit to the medical treatment proposed'.¹⁹² Later, in *Chappel v Hart*, the duty was described as 'a rigorous legal obligation' so 'conducive to respect for the

186 Ibid [68] (Davies AJA), [1] (Mason P agreeing), [8] (Beazley JA agreeing). See also at [69] (Davies AJA).

187 *Elbourne v Gibbs* [2006] NSWCA 127, [82] (Basten JA), [1] (Beazley JA agreeing). There it was held that 'it cannot be said that the defendant has shown that there would have been no reduction of risk had the relevant warnings been given. On balance, the evidence suggests the contrary': at [104] (Basten JA). Cf *Chester v Afshar* [2005] 1 AC 134, discussed in Part V below, where causation was found even though, had the surgery been postponed and performed at a later date or by a different doctor, the one to two per cent risk of neurological damage, or cauda equina syndrome, would have remained: at 142, 146–7 (Lord Steyn), 154–5, 161–3 (Lord Hope), 164–6 (Lord Walker) ('*Chester*').

188 (1998) 195 CLR 232, 277.

189 [2000] QSC 310, [10]–[11] (Dutney J).

190 *Wallace v Kam* (2013) 250 CLR 375, 385 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). See generally *Neville v Lam [No 3]* [2014] NSWSC 607, [174] (Beech-Jones J).

191 See generally Thomas Faunce, 'Disclosure of Material Risk as Systems-Error Tragedy: *Wallace v Kam*' (2013) 21 *Journal of Law and Medicine* 53.

192 (1992) 175 CLR 479, 482 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ), affd *Chappel v Hart* (1998) 195 CLR 232, 256–7 (Gummow J). In *Rosenberg v Percival* (2001) 205 CLR 434, 477 (Kirby J) (citations omitted), a patient's 'right to determine what shall be done with his own body' was stated to be '[f]undamental to the formulation adopted by [the] Court in *Rogers*'. See also Jeremy Clarke, 'Causation in *Chappel v Hart*: Common Sense or Coincidence?' (1999) 6 *Journal of Law and Medicine* 335, 337–8.

integrity of the patient and better health care' that,¹⁹³ when it is not complied with, 'it should occasion no surprise that legal consequences follow'.¹⁹⁴ The *Ipp Report* considered that liability for non-disclosed risks might be rationalised on the basis of the 'responsibilities of doctors to their patients', stating that according to *Chappel v Hart*, 'the doctor should be liable because the risk that materialised was precisely the risk about which (in discharge of the reactive duty) he should have warned the patient'.¹⁹⁵ Waddams forms the view that compensation was justified on the basis of Hart's 'intangible loss' to 'autonomy and dignity for not being permitted to make a fully informed decision'.¹⁹⁶

If these comments are read as implying that, in order to promote the performance of the duty and the protection of informed patient decision-making, liability *ought* to be imposed as soon as failure to warn of a material risk is shown, the courts' findings in *Wallace*¹⁹⁷ – as to the purpose of the duty of care and its application to deny liability – may, at first glance, seem to represent a tightening of the High Court's own previously stated objects of negligence liability in this area. They may also appear to de-emphasise patient autonomy or the protection of this right. Indeed, one's right to decision-making autonomy may initially seem weakened by a rule that denies liability, despite the non-disclosure of multiple risks of injury, on the basis that although it would have been avoided had all information been known, the only risk of harm that occurred was one which, in isolation, the patient was willing to accept.

Although the approach in *Wallace* may appear to disregard the patient's right to determine whether or not to run non-disclosed risks, it must be remembered that the medical practitioner's duty to advise of material risks inherent in undergoing or forgoing treatment takes the form of an action in negligence and

193 (1998) 195 CLR 232, 272 (Kirby J).

194 Ibid 277 (Kirby J). See also *Rosenberg v Percival* (2001) 205 CLR 434, 480, 484 (Kirby J).

195 *Ipp Report*, above n 5, 116. See also at 119; *Chester* [2005] 1 AC 134, 144 (Lord Steyn), 158–60 (Lord Hope), 163–6 (Lord Walker). In *Chappel v Hart* (1998) 195 CLR 232, 262, Gummow J stated that 'the obtaining of adequate advice as to the risks involved was a central concern of Mrs Hart in seeking and agreeing to undergo the surgical procedure in question. It would, in the circumstances of the case, be unjust to absolve the medical practitioner from legal responsibility'. See also at 257 (Gummow J), 276 (Kirby J).

196 Although only on the basis of a 'moderate' damages award: S M Waddams, 'Causation, Physicians and Disclosure of Risks' (1999) 7 *Tort Law Review* 5, 7.

197 See, eg, the discussion above nn 67–9, 75–9, 85–91 and accompanying text.

not battery.¹⁹⁸ It therefore requires a claimant to establish the causation of damage or harm as an essential element.¹⁹⁹ It is not then like an action in trespass which, being actionable per se or without proof of damage, is naturally more attuned to protecting against infringements of rights in the abstract, such as the right to bodily integrity.²⁰⁰ Justice Hayne arguably acknowledged this in *Chappel v Hart* when stating that it was not:

enough to say that a purpose of this area of the law is to promote reasonable conduct by medical practitioners and, particularly, the giving of advice necessary to enable people to make their own decisions about their lives. Enlarging the circumstances in which damages will be awarded if there has been a negligent failure ... may well tend to promote the giving of fuller advice. But the ambit of the liability is not to be decided only according to whether enlarging that ambit will promote careful conduct. The question of causation must still be answered.

198 In relation to medical treatment, battery actions are ‘confined to cases where surgery or treatment has been performed or given to which there has been no consent’ in broad terms, or where the consent given has been exceeded. It protects the patient’s ‘right to determine what shall be done with his own body’: *Reibl v Hughes* [1980] 2 SCR 880, 890 (Laskin CJ) (Martland, Dickson, Beetz, Estey, McIntyre and Chouinard JJ agreeing). ‘In situations where the allegation is that attendant risks which should have been disclosed were not communicated to the patient and yet the surgery or other medical treatment carried out was that to which the plaintiff consented’ the action lies in negligence. In such circumstances, it cannot ‘be said that the consent was vitiated by the failure of disclosure so as to make the surgery or other treatment an unprivileged, unconsented to and intentional invasion of the patient’s bodily integrity’: at 891. See also *Downer v Veilleux*, 322 A 2d 82, 89–90 (Duffrense CJ) (Weatherbee, Pomeroy, Wernick and Archibald JJ agreeing); *F v R* (1983) 33 SASR 189, 190 (King CJ); *Ellis v Wallsend District Hospital* (1989) 17 NSWLR 553, 578 (Samuels JA), 607 (Meagher JA agreeing); *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ); *Dean v Phung* [2012] NSWCA 223 [48]–[50], [61]–[64] (Basten JA); *Reeves v R* [2013] NSWCCA 34 (in the context of criminal medical assault).

199 See, eg, *Chappel v Hart* (1998) 195 CLR 232, 254 (Gummow J); *Tabet v Gett* (2010) 240 CLR 537. ‘[N]owhere is it suggested that the requirement for damage itself can be dispensed with. Liability based upon breach of duty of care without proven loss or harm will not suffice’: at 578 (Kiefel J), 564 (Hayne and Bell JJ agreeing), 575 (Crennan J agreeing).

200 See generally Braun, Skene and Merry, above n 179, 812. See also Danuta Mendelson, ‘Liability for Negligent Failure to Disclose Medical Risks’ (2001) 8 *Journal of Law and Medicine* 358, 359–61; *Reibl v Hughes* [1980] 2 SCR 880, 890–2 (Laskin CJ) (Martland, Dickson, Beetz, Estey, McIntyre and Chouinard JJ agreeing), discussed above n 198. The necessity to establish an element of tangible harm in negligence claims may be supported by the causation provisions in s 11 of the *Civil Liability Act 2003* (Qld): see, eg, Tina Cockburn and Bill Madden, ‘Intentional Torts Claims in Medical Cases’ (2006) 13 *Journal of Law and Medicine* 311, 333–4; cf *Corliss v Gibbings-Johns* [2010] QCA 233, [36] (Applegarth J), [1] (Holmes JA agreeing), [2] (Chesterman JJA agreeing).

What is the connection between the negligent act or omission and the damage sustained?²⁰¹

Additionally, actions in negligence demand an assessment of the reasonableness of conduct²⁰² which, in the context of a failure to advise independent of negligent mistreatment,²⁰³ necessarily reconciles a patient's interest in informed decision-making against the imposition upon practitioners of 'excessively onerous obligations of foresight and care'.²⁰⁴ Consequently, it has been said that expressions such as a 'right of self-determination', while perhaps suitable to trespass, are 'of little assistance in the balancing process that is involved' in negligence.²⁰⁵

With this in mind, a mere breach of duty or infringement of one's autonomy or right to choose has never guaranteed a successful negligence action such as to independently warrant recovery in *Wallace*. One's right to choose is not an interest that, absent more quantifiable²⁰⁶ or actionable damage, is recognised by negligence law as being capable of direct or absolute protection.²⁰⁷ Rather, in Australian medical negligence cases, claims for the loss of an opportunity to pursue a better therapeutic outcome are prohibited²⁰⁸ on the basis that the damage sustained is not the patient's loss of an ability to act to 'avoid or minimise' a risk of injury, but rather any physical injury suffered as a result.²⁰⁹ Previous failure to warn proceedings have also confirmed that compensation is awarded for actual

201 (1998) 195 CLR 232, 285–6 (citations omitted). See also Justice Kirby's statement:

Because in some cases the failure to warn would have no, or no relevant, consequences, proof of a breach will not of itself be sufficient to establish an entitlement to damages for every harm that thereafter occurs to the patient ... The plaintiff's legal obligation to show the causal connection remains ... at 272.

See also *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871, 883–5 (Lord Scarman); John G Fleming, *The Law of Torts* (LBC Information Services, 9th ed, 1998) 123. In the context of negligent diagnosis, *Paul v Cooke* (2013) 85 NSWLR 167 states that such arguments amount 'to no more than an invitation to disregard the requirement to establish causation, in order to reinforce the importance of the duty': at 172 (Ward JA agreeing), quoting *Paul v Cooke* [2012] NSWSC 840, [104] (Brereton J).

202 See, eg, *Tame v NSW* (2002) 211 CLR 317, 379 (Gummow and Kirby JJ).

203 See further above nn 137–40 and accompanying text.

204 Addison, above n 9, 3.

205 *Rogers v Whitaker* (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

206 See, eg, *Harriton v Stephens* (2006) 226 CLR 52, 126 (Crennan J), where, in the context of a negligence action for wrongful life, it was considered that '[b]ecause damage constitutes the gist of an action in negligence, a plaintiff needs to prove actual damage or loss and a court must be able to apprehend and evaluate the damage, that is the loss, deprivation or detriment caused by the alleged breach of duty'.

207 See, eg, '[i]f a right of choice exists in relation to some matter, than presumably anyone who causes the person with such a right to do anything he or she does not choose to do inflicts a form of legal harm. That is a loose concept': *Cattanach v Melchior* (2003) 215 CLR 1, 16 (Gleeson CJ).

208 *Tabet v Gett* (2010) 240 CLR 537, 554, 559 (Gummow ACJ), 580–2, 586–7 (Kiefel J), 564 (Hayne and Bell JJ agreeing), 575 (Crennan J agreeing).

209 *Chappel v Hart* (1998) 195 CLR 232, 239 (Gaudron J). See also at 252 (McHugh J); *Naxakis v Western General Hospital* (1999) 197 CLR 269, 280 (Gaudron J); *Rosenberg v Percival* (2001) 205 CLR 434, 464 (Gummow J); *Tabet v Gett* (2010) 240 CLR 537, 559 (Gummow ACJ), 581–2, 586–7 (Kiefel J), 564 (Hayne and Bell JJ agreeing), 575 (Crennan J agreeing).

damage to the person or the consequential occurrence of economic loss or expenditure.²¹⁰ Since negligence cannot enforce mere rights, compensation has not been provided for the patient's unknowing exposure to extra risk,²¹¹ or for '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'.²¹² Neither can a patient sue 'for the costs of, and inconvenience involved in, an entirely successful operation, in which none of the inherent risks that should have been the subject of a warning came home'.²¹³

As such, *Wallace* was justified in finding it 'consistent with the underlying purpose of the imposition of the duty to warn', that 'the damage suffered by the patient that the common law makes compensable is not impairment of the patient's right to choose', exposure to an 'undisclosed risk',²¹⁴ or failure to 'protect the integrity of the decision'.²¹⁵ The Court of Appeal instead cautioned against the uncritical use of such concepts 'which ought to be valuable currency, but which are susceptible to rhetorical inflation'.²¹⁶ *Wallace* confirms that in cases involving the non-disclosure of inherent material risk(s) of treatment, the law of negligence, particularly for the purpose of formulating an appropriate scope of liability in causation, does not directly protect the right to patient autonomy, or informed decision-making, against intrusion. Instead, such a right remains to be promoted only indirectly or incidentally by the duty (after the causation of actionable harm is shown), in the sense that without the provision of information '[a]ny "choice" by the patient, in respect of such procedures ... is "meaningless"'.²¹⁷

It should be noted, however, that *Wallace* was not a case where the claimant was arguing that he should be compensated for the mere infringement of his autonomy; physical injury was in fact sustained. Because *Wallace* did sustain a

210 See, eg, *Rosenberg v Percival* (2001) 205 CLR 434, 453 (Gummow J); L Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences* (LexisNexis Butterworths, 3rd ed, 2008) 198. See generally *Cattanach v Melchior* (2003) 215 CLR 1, 31–2 (McHugh and Gummow JJ).

211 *Chappel v Hart* (1998) 195 CLR 232, 240 (Gaudron J); M A Jones (ed), *Clerk & Lindsell on Torts* (Thomson Reuters, 20th ed, 2010) 62–4.

212 *Rosenberg v Percival* (2001) 205 CLR 434, 453 (Gummow J) (citations omitted). See also *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [14] (Allsop P).

213 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [15] (Allsop P).

214 *Wallace v Kam* (2013) 250 CLR 375, 381 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). See also '[t]he right to recover damages in the present case was put, in part, on the basis of upholding the autonomy of the patient to determine whether or not to have the procedure. That contention is, however, too broadly stated': *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 068 [159] (Basten JA).

215 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [14] (Allsop P).

216 *Ibid* 66 068 [160], quoting statements made in *Rosenberg v Percival* (2001) 205 CLR 434, 440 (Gleeson CJ).

217 *Rosenberg v Percival* (2001) 205 CLR 434, 465 (Kirby J), citing statements made in *Rogers v Whitaker* (1992) 175 CLR 479, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). See also *Wallace v Kam* (2013) 250 CLR 375, 380–1 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). Cf the position under English law discussed below Part V.

recognised form of harm,²¹⁸ there was a possibility that the courts might find in his favour without departing from a consideration of established causation principles. The issue, then, revolved around the question of why scope of liability should not extend to encompass the *particular* form of harm that was in fact sustained. It was here that the High Court stated that it was ‘not necessarily appropriate for the liability of the medical practitioner to extend to every physical injury to a patient ... about which it is the duty of the medical practitioner to warn’.²¹⁹ What qualifies as actionable damage in this way has been recognised as being ‘a question of policy largely defined by the “duty” rules’.²²⁰ Consequently, the Court concluded that it was the purpose of the law of negligence that the duty to inform of material risks is only ‘imposed to enable the patient to choose whether or not to run those inherent risks and thereby “to avoid the occurrence of the particular physical injury the risk of which [the] patient is not prepared to accept”’.²²¹

Nevertheless, if viewed in terms of autonomy promotion, a patient’s informed decision-making is arguably only minimally impacted by non-disclosure of a single material risk, which is totally independent of any other risk and which, if warned of, would have been accepted by virtue of the patient’s continuance with the procedure. Here, as the provision of data is inconsequential to the patient’s assessment or undertaking of risk, the enablement of relevantly enlightened choice is preserved by the law’s exclusion of liability. In addition to not satisfying factual causation,²²² as it does not involve exposure to physical injury the risk of which was unacceptable to the patient, neither is the imposition of liability supported by *Wallace*’s formulation of the purpose of the duty of care in terms of scope of liability. By contrast, in circumstances involving multiple risks, where the patient alleges that had one of the risks been disclosed they would not have undergone the procedure at all or at that time, it is arguable that after *Wallace* the efficacy of any indirect protection of patient autonomy has been eroded, or will certainly depend on how the risk (or risks) is (or are) defined.

C The Nature and Classification of Risks: Distinct Versus Cumulative

In *Wallace*, it was recognised that the patient’s decision regarding whether or not to proceed with the surgery needed to be made on the basis of an

218 Namely, physical injury in the form of neurapraxia: see generally *Wallace v Kam* (2013) 250 CLR 375, 390 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). Such ‘personal injury’ is also recognised within the Civil Liability Legislation’s definition of ‘harm’: *Civil Liability Act 2002* (NSW) s 5; *Civil Liability Act 2003* (Qld) s 8, sch 2; *Wrongs Act 1958* (Vic) s 43; *Civil Liability Act 1936* (SA) s 3; *Civil Liability Act 2002* (WA) s 3; *Civil Liability Act 2002* (Tas) s 9; *Civil Law (Wrongs) Act 2002* (ACT) s 40.

219 *Wallace v Kam* (2013) 250 CLR 375, 387 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

220 Fleming, above n 201, 216.

221 *Wallace v Kam* (2013) 250 CLR 375, 381 (French CJ, Crennan, Kiefel, Gageler and Keane JJ) (citations omitted). See also at 390; *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [14] (Allsop P).

222 See above n 165 and accompanying text.

assessment of all of the risks, ‘which should have been disclosed ... in one body of disclosure’.²²³ Importantly however, it was stated that the courts’ normative findings under scope of liability were greatly influenced by ‘the distinct nature of the material risks about which Dr Kam failed to warn Mr Wallace’.²²⁴ In this case, ‘[t]here was no suggestion that the neurapraxia was medically related to the risk of catastrophic paralysis’,²²⁵ rather they were treated as ‘distinct risks of different physical injuries’.²²⁶ On this basis, given that Wallace would have proceeded with the surgery had he known of the risk of neurapraxia, it could not be shown that non-disclosure of the more catastrophic paralysis risk (estimated to occur in around five per cent of cases) exposed him to a type of physical injury (in terms of the *actual* harm, or neurapraxia, suffered) the risk of which was *unacceptable to him*.²²⁷ Rather, ‘[w]hat was not acceptable was the combination of all the risks such that the *procedure* became unacceptable’.²²⁸ Accordingly, while Wallace may have objected to the ‘level of risk of physical injury occurring’ overall, unlike Beazley JA,²²⁹ the High Court held that the ‘risk of physical injury that comes home in such a case is not necessarily the risk of [*particular*] physical injury that is unacceptable to the patient’.²³⁰

The case therefore highlights the importance – at least in terms of future cases involving a failure to warn of multiple risks – of the distinction between *distinct* and *cumulative* risks. Distinct risks are perils that are not medically related, such as the risk of a fractured jaw and the risk of a dry socket due to the removal of wisdom teeth. With distinct risks, as stated by Basten JA in *Wallace*, ‘[a]lthough the patient has but one decision to make, the factors to be placed into the balance in making that decision ... are separate and each has its own weight’.²³¹ As such, *Wallace* would seem to provide authority for the proposition that, in a case concerning a failure to warn of multiple risks, the non-disclosure of one distinct risk will never impact upon the patient’s decision as to whether another is acceptable.²³² Cumulative risks however, are those which cannot be ‘disentangled’ from each other. These latter risks may have a ‘bearing on the

223 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 049 [21] (Allsop P). See also at 66 045 [8] (Allsop P).

224 *Wallace v Kam* (2013) 250 CLR 375, 388 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). See also at 390–1. See further, ‘[o]f importance to that equiparation is the separateness and distinctiveness of the risks, which the argument of the appellant below and in this Court implicitly recognised’: *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 050 [28] (Allsop P).

225 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 049 [21] (Allsop P). See also at 66 050 [31] (Allsop P).

226 *Wallace v Kam* (2013) 250 CLR 375, 389 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

227 See above nn 67–9, 85–91 and accompanying text.

228 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [17] (Allsop P) (emphasis added).

229 See above nn 70–4 and accompanying text.

230 *Wallace v Kam* (2013) 250 CLR 375, 389 (French CJ, Crennan, Kiefel, Gageler and Keane JJ) (emphasis added). See also at 388.

231 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 070 [170].

232 Ibid 66 047 [16]–[17] (Allsop P). However, this is subject to the discussion at below Part IV(D).

likelihood of the other occurring' or have a 'relevant medical relationship or connection',²³³ such that the non-disclosure of one or more cumulative risks affects the acceptability of the others or of the degree of particular injury that might occur.²³⁴ President Allsop states that, hypothetically on the facts of *Wallace*:

If the occurrence of neurapraxia was disclosed that risk may have been acceptable in itself with its usual consequences; but if neurapraxia could, in some cases, trigger other catastrophic neurological consequences it would be impossible to say that the risk of neurapraxia had been accepted, even though only the 'usual' consequences and discomfitures of it had manifested themselves.²³⁵

In considering the distinction between distinct and cumulative as outlined in *Wallace*, it is possible to refer to a number of other cases that have involved cumulative risks, despite the fact that the courts have not always explicitly classified the risks in that way. An example of further disclosure bearing on the acceptability of a risk of oesophagus perforation is illustrated by *Chappel v Hart*. There, injury to a patient's voice resulted from a 'sequence of the perforation, the infection (mediastinitis), the damage to the laryngeal nerve and the paralysis of the right vocal cord'.²³⁶ Only the risk of perforation had been mentioned as a complication,²³⁷ and it was held that given the interconnected nature of each risk, it was 'the relevant conjunction of circumstances' that 'should have been the subject of any adequate warning'.²³⁸ In *Rogers v Whitaker*, the non-disclosed risk of sympathetic ophthalmia occurring as a result of the patient's eye surgery was 'once in approximately 14,000 such procedures, although there was also evidence that the chance of occurrence was slightly greater when, as [was the case in *Rogers*], there had been an earlier penetrating injury to the eye operated upon'.²³⁹ Therefore, had it been disclosed, in order for a patient to accept it, both the probability of the risk of ophthalmia and the circumstances of the individual patient which had increased the risk occurring would need to have been known. Similarly, in *Wallace*, the claimant's weight was said to have increased both the probability of the risk of neurapraxia and its magnitude,²⁴⁰ while in *Bloodworth v South Coast Regional Health Authority*, a non-disclosed risk of abdominal surgery was held to increase with both the practitioner's inexperience and the slowness of the patient, such that all risk components should have been

233 Ibid 66 047 [18] (Allsop P). See also at 66 050 [30] (Allsop P), 66 071 [172] (Basten JA); *Amaca Pty Ltd v Ellis* (2010) 240 CLR 111, 131–2 (French CJ, Gummow, Hayne, Heydon, Crennan, Kiefel and Bell JJ).

234 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [17] (Allsop P). See also *Wallace v Kam* (2013) 250 CLR 375, 389 (French CJ, Crennan, Kiefel, Gageler and Keane JJ).

235 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [17] (Allsop P).

236 *Chappel v Hart* (1998) 195 CLR 232, 254 (Gummow J).

237 Ibid.

238 Ibid 257 (Gummow J). The risks were described by his Honour as 'cumulative': at 261.

239 (1992) 175 CLR 479, 482 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

240 *Wallace v Ramsay Health Care Ltd* [2010] NSWSC 518, [47] (Harrison J); *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 052 [46] (Beazley JA).

revealed.²⁴¹ In *Bloodworth*, the material risk in question was expressed as the danger of ‘sustaining abdominal injury as a result of the blind insertion of the veress needle and the trocar’ in laparoscopic surgery.²⁴² Consequently, as the risk of injury due to such sharp instruments was affected by both patient build and practitioner experience, in this context the risk components, post-*Wallace*, would be cumulative. In *Moyes v Lothian Health Board*, whilst a patient’s hypersensitivity had not caused their stroke following an angiography, it was a ‘cumulative’ factor ‘aggravating the risks’ of stroke such that it was held to be an ‘added risk’ of which the patient should have been warned.²⁴³ Lord Caplan noted that:

If we were to suppose a situation where an operation would give rise to a 1 percent risk of serious complication in the ordinary case but where there could be four other special factors each adding a further 1 percent to the risk, a patient to whom all five factors applied might have a 5 percent risk rather than the 1 percent risk of the average person. It is perfectly conceivable that a patient might be prepared to accept the risk of one in 100 but not be prepared to face up to a risk of one in 20.²⁴⁴

In these circumstances then, failure to disclose one component of the risk would expose the patient, in total, to a greater extent, likelihood, or risk of particular physical injury than they may have been willing to accept on the basis of any component known. Consequently, while perhaps seeming unlikely, cases involving cumulative risks do have the potential to occur quite often. As such, in future actions based upon a failure to disclose material risk, there may be particular benefit in forming a cumulative risk argument, if such an argument then allows the patient to show that the physical injury sustained was regarded as an unacceptable risk.²⁴⁵ However, the ability to form such an argument will depend upon the following factors.

1 The Description of Multiple Risks

Whether non-disclosure amounts to ‘one interconnected failure to disclose all relevant inherent risks will depend upon a factual enquiry’²⁴⁶ that is likely to be significantly assisted by medical evidence and the science of risk relationships.

241 [2004] NSWSC 234, [141]–[159] (Mathews AJ) (*‘Bloodworth’*).

242 Ibid [144] (Mathews AJ).

243 1990 SLT 444, 447 (Lord Caplan). On the facts, however, liability was not found as it could not be established that such a warning would have prevented the operation.

244 Ibid.

245 As discussed above nn 162, 208 and accompanying text, following *Tabet v Gett* such actions cannot take the form of a loss of a chance claim. That is, they cannot be argued on the basis that the non-disclosure of all cumulative risk components has led the patient to make decisions about a procedure that has deprived them of the chance of a better medical outcome such that it is that *lost chance*, rather than *physical injury* actually sustained, that they are seeking compensation for: *Tabet v Gett* (2010) 240 CLR 537, 554, 559 (Gummow ACJ), 580–2, 586–7 (Kiefel J), 564 (Hayne and Bell JJ agreeing), 575 (Crennan J agreeing).

246 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 045 [8] (Allsop P). See also at 66 047 [18] (Allsop P), 66 070 [170] (Basten JA).

However, the enquiry is also likely to be influenced by the way in which the risk is 'described to the patient and the way in which it will be understood and assessed'.²⁴⁷ For example, in *Wallace*, the supposedly distinct risks were, in fact, both forms of nerve damage. The first, bilateral femoral neurapraxia, was a risk of 'local nerve damage to the thigh' due to lying for an extended period throughout the surgery.²⁴⁸ The second, a five per cent risk of paralysis, arose due to the 'risk of injury to the spinal nerves during the course of the operation causing paralysis'.²⁴⁹ Indeed, in *Sidaway v Board of Governors of the Bethlem Royal Hospital*, it was recognised that a general warning of a one to two per cent risk of nerve root damage in the area of the operation encompassed the potential for spinal cord damage, such that there was no separate obligation to advise of the latter, more specific, risk.²⁵⁰ Alternatively, as Wallace's injury due to the neurapraxia was described as 'incomplete paraplegia',²⁵¹ both risks might be understood in terms of paraplegia.

As a consequence, an issue may arise where risks – although on one view distinct and separate – are grouped together as a body of similar risks by the medical practitioner when describing them as part of their duty to advise. For example, given that 'clinicians tend to be overly general in their descriptions of some risks',²⁵² suppose that the practitioner in *Wallace* did provide a risk warning but framed it more broadly in terms of an 'x' per cent chance of 'nerve damage'. The warning given is a single warning that encompasses both neurapraxia and paralysis, instead of a number of distinct warnings of the differing physical manifestations or substances of the particular risk in question. Would the risks now be cumulative, such that the non-disclosure of the paralysis component would mean that the patient would be exposed to a substantially greater risk of nerve damage that was now unacceptable to them, and succeed in their claim, even if the risk of neurapraxia was accepted? Should an, albeit indirect, protection of patient autonomy²⁵³ be forced to turn upon such fine distinctions or matters of linguistics? When practitioners' conversations surrounding risks and consent are routinely 'customized to suit individual patients',²⁵⁴ should liability also depend upon, for example, a patient expressing a particular concern (for some reason) about sustaining nerve damage and therefore being advised of the

247 Ibid 66 070 [170] (Basten JA).

248 Ibid 66 050–51 [36] (Beazley JA).

249 Ibid.

250 [1985] AC 871, 902–5 (Lord Templeman). See also at 891–2 (Lord Diplock), 900–1 (Lord Bridge), 895 (Lord Keith agreeing).

251 See, eg, Ian Wallace, 'Appellant's Amended Submissions', Submission in *Wallace v Kam*, S307/2012, 1 November 2012, [21].

252 Bismark et al, above n 10, 3.

253 See above Part IV(B).

254 Christopher F C Jordens, Kathleen Montgomery and Rowena Forsyth, 'Trouble in the Gap: A Bioethical and Sociological Analysis of Informed Consent for High-Risk Medical Procedures' (2013) 10 *Journal of Bioethical Inquiry* 67, 72.

risks in those terms? The reasoning in *Wallace* is unlikely to assist in resolving such questions, due to the fact that the only view expressed was that the risks in that case, being distinct, should have been considered separately.²⁵⁵ The possibility that they could have been cumulative, based on the way in which the risks were described, was therefore beyond the courts' contemplation.

2 *The Patient's Subjective Circumstances*

In terms of subjective characteristics, Allsop P in *Wallace* considered that the relationship of risks to each other also depends upon 'the attitude or background'²⁵⁶ or 'known relevant connection[s] for the patient'.²⁵⁷ Based on this reasoning, it can be argued, in a similar way to assessing whether a risk is material,²⁵⁸ that an assessment of whether risks are cumulative may be influenced by a patient's subjective medical and non-medical traits. If this is possible, individual patient circumstances may result in a collection of risks being classed as cumulative *for that individual*, even if this would not be so for another patient. For example, consider the situation of an opera singer about to have throat surgery. Due to their circumstances (like the principal education officer in *Chappel v Hart*),²⁵⁹ the patient is particularly concerned about possible damage to their voice. As a result of the surgery there are two distinct risks, 'x' and 'y'. If both risks have the potential to affect the patient's voice, are they now, given the situation of the particular patient, cumulative? Notably, this argument is not intended, necessarily, to be the same as the linguistic argument referred to above, which instead turns on the way in which the risks are presented (for instance as 'risks to voice') rather than on how they may appear to be interconnected from the viewpoint of the particular patient.

As such, the ability of *Wallace's* distinction – between distinct and cumulative risks – to provide clarity in practice, must be questioned. As discussed below, it must also be queried whether such a differentiation between types of risk actually accords with the way in which patients make decisions.

D *Wallace and the Complex Nature of Patient Decision-Making*

The categorisation of both non-disclosed material risks in *Wallace* as distinct meant that the medically unrelated risk of paralysis was deemed irrelevant to the

255 See above nn 90, 223–7 and accompanying text.

256 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 045 [8].

257 Ibid 66 047–8 [18]. See also at 66 050 [30] (Allsop P).

258 See above nn 5–9 and accompanying text. See, eg, *Rosenberg v Percival* (2001) 205 CLR 434, 458, where Gummow J stated that 'if ... as in *Rogers*, the patient is already blind in one eye and stands to lose sight entirely, that risk becomes one of an altogether greater magnitude'.

259 (1998) 195 CLR 232, 253 (Gummow J), 266 (Kirby J). Indeed, the patient in *Chappel v Hart* was described as 'a person for whom the potential consequences of damage to her voice were more significant than the "statistical" risk': at 257 (Gummow J).

issue of whether Wallace's neurapraxia was unacceptable to him.²⁶⁰ Such an approach then relies on an assumption that, in the case of multiple non-disclosed material risks, a patient will analyse each distinct risk separately and in isolation from another when making decisions about medical procedures. It also equates to a view that the relationship between distinct material risks is always irrelevant when patients weigh information during the consent process.

It might be correct to form the view that, during the decision-making process, a patient may turn their mind to a separate consideration of the *physical consequences* of each distinct risk should one or more of those risks come home. However, in circumstances where all risks are material to the patient, Wallace's approach does not pay *any* regard to the way in which, within the ambit of the appropriate scope of liability set by their Honours, the patient may weigh *all* material information together. Patient decision-making about whether to undergo or forgo medical treatment has been described as a multifaceted phenomenon²⁶¹ which 'typically involve complex trade-offs between probable harms and benefits'.²⁶² The issue therefore arises as to whether it is just to conclude that the non-disclosure of one distinct risk (of particular physical injury) will *never* impact upon a patient's decision regarding the acceptability of another.²⁶³

It can be questioned whether, in Wallace, Basten JA was justified in reasoning that, while patients contemplate a procedure's cumulative risks together in decision-making, they consider each medically unrelated discrete risk separately by giving it its own weight.²⁶⁴ Notably, his Honour admits that this is a 'somewhat idealised paradigm'.²⁶⁵ According to previous High Court jurisprudence, patients often understand the disclosure of risk information only imperfectly.²⁶⁶ Lord Caplan, in *Moyes v Lothian Health Board*, also noted that '[t]he ordinary person who has to consider whether or not to have an operation is

260 See above nn 223–7 and accompanying text.

261 See, eg, Amin Hakim, 'Perception of Risk and Benefit in Patient-Centered Communication and Care' (2011) 3 *Journal of Patient Intelligence* 39.

262 Jordens, Montgomery and Forsyth, above n 254, 70 (observation made in the context of studying high risk medical procedures, namely bone marrow transplantation). See also *Reibl v Hughes* [1980] 2 SCR 880, 899 (Laskin CJ) (Martland, Dickson, Beetz, Estey, McIntyre and Chouinard JJ agreeing).

263 This is considered to be a different argument to that made by Beazley JA (in dissent) in *Wallace v Kam* [2012] Aust Torts Reports ¶82–101. While her Honour focused upon the patient's acceptance of the *overall risks of treatment* such that the *procedure* became unacceptable, this was distinguished by the majority judges in the Court of Appeal and the High Court: see above nn 70–4, 86–9, 223–30 and accompanying text. Accordingly, our question is framed within the ambit of the appropriate scope of liability, or purpose of the duty of care, formulated by the majority in asking whether the non-disclosure of distinct risks can subject a patient to a *particular physical injury* the risk of which is unacceptable to them: see above nn 168–70 and accompanying text.

264 See above n 231 ff and accompanying text. See also *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 047 [16]–[17] (Allsop P).

265 Ibid 66 070 [170] (Basten JA).

266 *Rosenberg v Percival* (2001) 205 CLR 434, 478 (Kirby J).

not interested in the exact pathological genesis of the various complications which can occur but rather in the nature and extent of the risk'.²⁶⁷

This acknowledges that patients may not make the type of distinction between distinct and cumulative risks proposed by *Wallace*. Rather, it appears counterintuitive to the way in which patients make decisions to say that *distinct* risks of different physical injuries will never impact upon an individual's acceptance of other *distinct* risks, and that instead patients only make decisions by saying (in effect): 'yes I will accept risk "a"; yes I will accept risk "b"; yes I will accept risk "c"; so yes I will have the procedure'.

After studying patients' information use in deciding between treatments for symptomatic carotid artery disease, Bergus, Levin and Elstein concluded that, as subjects learned more about a treatment's risks and benefits, their 'favorability ratings', or likelihood of going ahead with a treatment, declined,²⁶⁸ and 'that, overall, risks affected judgments more than benefits'.²⁶⁹ This does not necessarily support the view that subjective characteristics may result in patients treating risks as *cumulative*.²⁷⁰ Nonetheless, if it is the situation that the more a patient learns about risks, the 'more conservative' their choices become,²⁷¹ then surely one might argue that the more *distinct* risks, 'd', 'e', 'f' and so on, that a patient has to consider, the similarly less likely it is that a risk of physical injury 'a' might be acceptable to them.

The following example illustrates this further: Sue is considering cosmetic surgery in the form of an abdominoplasty, or tummy tuck. The surgery is purely elective as there is no medical necessity to have it. Possible risks of the procedure include: infection; numbness; fluid accumulation; hematoma; skin discolouration; and blood clots or stroke. All risks are material. Sue is advised of the risk of infection. Her surgeon does not advise her of any of the other risks. Given the perceived benefits of the procedure (in terms of her appearance), Sue is comfortable accepting the risk of infection and has the procedure. She develops an infection.

On the authority of *Wallace*, although Sue's surgeon did not advise her of *all* material risks, she would not be able to receive compensation for her infection. Sue is comfortable with this risk, and because it would be classed as distinct, non-disclosure of the other risks would ostensibly not operate to make it a type of

267 1990 SLT 444, 447 (Lord Caplan). President Allsop acknowledges that this has a 'degree of persuasion': *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 050 [29].

268 George R Bergus, Irwin P Levin and Arthur S Elstein, 'Presenting Risks and Benefits to Patients: The Effect of Information Order on Decision Making' (2002) 17 *Journal of General Internal Medicine* 612, 616.

269 Ibid.

270 See above nn 256–9 and accompanying text.

271 '[W]hen provided with information and opportunity for greater involvement in decisions, consumers generally become more wary of the treatments offered and make more conservative choices': A Edwards and G Elwyn, 'Understanding Risk and Lessons for Clinical Risk Communication about Treatment Preferences' (2001) 10(Supp 1) *International Journal for Quality in Health Care* i9, i12.

physical injury that was unacceptable to her. Yet surely Sue might reasonably argue that, while she may have been willing to accept the nature of the risk of infection if that had been the only material risk involved, had she known of even one other risk (say of numbness), let alone the others, she would not then have been willing to chance infection? Therefore, is there not a point at which information about other distinct risks will affect individual acceptance of another? The High Court may argue that the real issue here is not the acceptance of an individual risk of particular physical injury but the combination of all the risks such that the *procedure* (rather than the risk of harm that occurred) became unacceptable.²⁷² But given that *all* material risks are relevant to an enquiry concerning factual causation,²⁷³ is that not a bit like trying to eat one's cake whilst keeping it too? In such a situation, even if Sue's argument was accepted, she would still need to establish that she would not have had the procedure ever, or at that time, had all information, including that not disclosed, been known.²⁷⁴ Such factual causation is often hard to establish,²⁷⁵ and may be particularly so where surgery is elective.²⁷⁶ It is worth remembering in this regard that the courts in *Wallace* did not determine, as a matter of evidence, what the patient would have done if he had been advised of both risks, but instead assumed this for the purpose of considering the causation issues.²⁷⁷

Consequently, *Wallace* pays insufficient regard to the way in which patients may make decisions concerning procedures that carry multiple risks and, in doing so, its analysis and treatment of distinct risks arguably erodes the indirect protection²⁷⁸ of a patient's right to informed decision-making promoted by the duty to warn. However, as outlined below, the High Court's approach to rights protection is notably different to the position under English law, which has developed in a way that protects individual autonomy more directly.

272 See above nn 228–30 and accompanying text; above n 263.

273 See above nn 152–4 and accompanying text.

274 See above nn 157–65 and accompanying text.

275 See, eg, 'establishing a causal connection between medical negligence and the damage alleged is often the most difficult task for a plaintiff in medical malpractice litigation': *Chappel v Hart* (1998) 195 CLR 232, 264 (Kirby J).

276 As stated by Addison, above n 9:

The recent trend of the case law suggests that courts are less inclined to find causation in cases involving elective cosmetic procedures. This supports the proposition that cosmetic surgery patients may have a 'picture in their mind's eye' which potentially overrides the caution of a reasonable person who would refuse surgery on the grounds of potential risks: at 22 (citations omitted).

277 See discussion above nn 63–6, 84 and accompanying text.

278 See above Part IV(B).

V CONTRASTING WALLACE WITH THE APPROACH UNDER ENGLISH LAW

Wallace's de-emphasised protection of the notion of patient autonomy in negligence cases concerning information disclosure can be contrasted with the approach adopted by the House of Lords in *Chester*.²⁷⁹ There are significant differences between the Australian and English legal frameworks relevant to a medical practitioner's obligation to disclose risk,²⁸⁰ and it is not intended that a detailed account of these differences be provided here. Instead, this Part seeks merely to demonstrate the greater prioritisation of patient autonomy evident under English law. This is significant because, although *Wallace*'s formulation of scope of liability²⁸¹ is taken from Lord Steyn's judgment in *Chester*,²⁸² an application of the reasoning adopted by the House of Lords provides an illuminating example of how the High Court could have arrived at a very different result by giving greater force (or at least, a wider scope) to the duty's underlying purpose in terms of its potential to protect patient rights. Thus, this comparison raises the question of why, when the factual causation of physical harm could potentially be established, the High Court was so reluctant to give full effect to the scope and purpose of the practitioner's duty to warn.

Chester considered a patient's ability to recover damages for a surgeon's failure to warn of a one to two per cent risk of cauda equina syndrome, or neurological injury, which was material and which did in fact eventuate following spinal surgery.²⁸³ For causation purposes, it was not certain that the patient would have completely refused the procedure had she known of the risk of developing the syndrome, but it was argued that she would have postponed the procedure and sought alternative advice.²⁸⁴ The claimant's case in *Chester* was therefore based on a similar argument to that pursued by the patient in *Chappel v Hart*.²⁸⁵ Akin to *Chappel v Hart*, because the chance of the risk occurring was very low, the 'but for' test was regarded as satisfied because, on the balance of probabilities, the risk would not have eventuated if the surgery had been performed on another day.²⁸⁶ However, contrary to *Chappel v Hart*, where a

279 [2005] 1 AC 134.

280 For a discussion of the duty of care and the obligation of disclosure in England, see, eg, Alasdair Maclean, 'From *Sidaway* to *Pearce* and Beyond: Is the Legal Regulation of Consent Any Better Following a Quarter of a Century of Judicial Scrutiny?' (2012) 20 *Medical Law Review* 108.

281 Being limited to the avoidance of 'particular physical injury the risk of which [the] patient is not prepared to accept': *Wallace v Kam* (2013) 250 CLR 375, 381 (French CJ, Crennan, Kiefel, Gageler and Keane JJ) (citations omitted). See also above nn 69, 89, 170 and accompanying text.

282 [2005] 1 AC 134, 144. See also *Wallace v Kam* (2013) 250 CLR 375, 381 (French CJ, Crennan, Kiefel, Gageler and Keane JJ); below n 290 and accompanying text.

283 [2005] 1 AC 134, 140, 142, 148–51.

284 Ibid 141–2, 147–50, 154.

285 (1998) 195 CLR 232, discussed above nn 160, 183, 236 and accompanying text.

286 *Chester* [2005] 1 AC 134, 144 (Lord Steyn), 154–5, 161 (Lord Hope), 164 (Lord Walker).

reduction in risk could be shown had the surgery been delayed, in *Chester* the ‘injury would have been as liable to occur whenever the surgery was performed and whoever performed it’.²⁸⁷ Consequently, as the negligence had neither increased the claimant’s risk exposure nor exposed them to an unacceptable risk, success in *Chester v Afshar* required a departure from purportedly established causation principles.²⁸⁸

In a 3:2 majority of the House of Lords, Lords Steyn, Hope and Walker, concluded that the claim should succeed.²⁸⁹ Lord Steyn’s reasoning was framed as follows:

Individuals have a right to make important medical decisions affecting their lives for themselves: they have the right to make decisions which doctors regard as ill advised. ... [N]ot all rights are equally important. But a patient’s right to an appropriate warning from a surgeon when faced with surgery ought *normatively* to be regarded as an important right which must be given effective protection whenever possible. ... [I]n the context of attributing legal responsibility, it is necessary to identify precisely the protected legal interests at stake. A rule requiring a doctor to abstain from performing an operation without the informed consent of a patient serves two purposes. It tends to *avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept*. It also ensures that due respect is given to *the autonomy and dignity of each patient*. ... [I]t is a distinctive feature of the present case that but for the surgeon’s negligent failure to warn the claimant of the small risk of serious injury the actual injury would not have occurred when it did and the chance of it occurring on a subsequent occasion was very small. It could therefore be said that the breach of the surgeon resulted in the very injury about which the claimant was entitled to be warned. ... I have come to the conclusion that, as a result of the surgeon’s failure to warn the patient, she cannot be said to have given informed consent to the surgery in the full legal sense. *Her right of autonomy and dignity can and ought to be vindicated* ...²⁹⁰

Lord Hope also observed that ‘the issue of causation cannot be properly addressed without a clear understanding of the scope of [the] duty’.²⁹¹ Therefore, because ‘the law which imposed the duty to warn on the doctor has at its heart the right of the patient to make an informed choice as to whether, and if so when and by whom, to be operated on’, to leave the patient without a remedy ‘would

287 Ibid 141 (Lord Bingham). See also at 140 (Lord Bingham), 142 (Lord Steyn), 147 (Lord Hoffmann), 154, 156, 161 (Lord Hope), 164–5 (Lord Walker). Lord Hoffmann, in dissent, considered that ‘the purpose of a duty to warn someone against the risk involved in what he proposes to do, or allow to be done to him, is to give him the opportunity to avoid or reduce that risk’: at 147.

288 Ibid 139–40 (Lord Bingham), 142–3 (Lord Steyn), 147 (Lord Hoffmann), 161–3 (Lord Hope), 166 (Lord Walker). See also Jones (ed), above n 210, 64. It should also be noted that, unlike the approach now adopted by the Australian High Court: above nn 44–8, 80–3, 99–100 and accompanying text, in determining causation in *Chester*, issues of factual and normative causation or scope of liability tended to be conflated by the House of Lords.

289 *Chester* [2005] 1 AC 134, 146–7 (Lord Steyn), 161–3 (Lord Hope), 163–6 (Lord Walker); cf 141–2 (Lord Bingham), 147–8 (Lord Hoffmann).

290 Ibid 143–6 (emphasis added) (citations omitted).

291 Ibid 151. See also at 163 (Lord Walker).

render the duty useless in the cases where it may be needed most'.²⁹² Acknowledging 'the importance of personal autonomy' as a 'basic human right', Lord Walker agreed with Lords Steyn and Hope.²⁹³

Although noting that the purpose of the duty to warn was, in part, to protect patients from consenting to procedures containing unacceptable or increased risk(s) of particular physical injuries, in *Chester*, the majority's approach to causation was primarily focused upon protecting the patient's right to autonomous decision-making. According to Wheat, '[t]he decision is effectively acknowledging ... that the failure to respect this right will result in compensation being awarded for infringement of that right *per se*'.²⁹⁴ Other commentators have similarly observed that the 'primary concern of the majority in [*Chester*] was to ensure that patient autonomy is respected'.²⁹⁵ As such, their Lordships concluded that 'policy grounds' supported a causation finding,²⁹⁶ independently of a patient's ability to show a consequent increase in risk, whenever there is a negligent failure to disclose and the harm that occurs is 'the very risk' about which the patient 'should have been warned'.²⁹⁷

Given that the policy underpinning the finding of causation in *Chester* was based upon a violation of patient autonomy, it might be reasonable to conclude that the assertions of Wheat and others are accurate in terms of the position under English law. *Wallace*, on the other hand, confirms that a violation of autonomy or self-determination – in the form of failing to disclose material inherent risks of treatment – is not the guiding principle for determining whether it is appropriate for scope of liability to extend to a medical practitioner under Australian law.²⁹⁸ *Wallace* suggests that the question of whether the patient is willing to *accept* the risk that eventuated takes precedence over the notion of their *knowledge* of that risk for the purpose of autonomous decision-making. Thus, the normative grounds underpinning the causation findings in the Australian decision of *Wallace* appear distinct to those relevant to English law.

On the authority of *Chester*, a case with identical facts to those of *Wallace* may be decided very differently if it were to be considered by an English court. We acknowledge that it is unlikely that the House of Lords in *Chester* was contemplating the very different and unique circumstances that arose in *Wallace*, where it was the disclosure of multiple risks that, on a 'but for' test of causation,

292 Ibid 162 (Lord Hope). See also at 152–6, 162–3 (Lord Hope), 166 (Lord Walker), affd *Ruddock v Taylor* (2003) 58 NSWLR 269, 286–7 (Ipp JA).

293 *Chester* [2005] 1 AC 134, 163.

294 Kay Wheat, 'Progress of the Prudent Patient: Consent after *Chester v Afshar*' (2005) 60 *Anaesthesia* 217, 218; cf *Chester* [2005] 1 AC 134, 142 (Lord Bingham), 147–8 (Lord Hoffmann).

295 See, eg, Sarah Devaney, 'Autonomy Rules OK: *Chester v Afshar*' (2005) 13 *Medical Law Review* 102, 107.

296 *Chester* [2005] 1 AC 134, 163 (Lord Hope). See also at 144–6 (Lord Steyn).

297 Ibid 163 (Lord Hope). See also at 144 (Lord Steyn), 164–6 (Lord Walker).

298 See, eg, above nn 214–17 and accompanying text.

would have resulted in the patient avoiding harm. However, *Wallace* was purportedly also a case where it could not be shown that non-disclosure of all relevant information exposed the patient to a degree of risk, in relation to the particular physical injury suffered, that was unacceptable to them.²⁹⁹ Requiring a normative determination about the extent, or scope, of a medical practitioner's liability, the views of the majority of the House of Lords in *Chester* may provide a basis to circumvent this issue, were it decided by the United Kingdom Supreme Court today,³⁰⁰ by justifying the imposition of liability on the basis of a wider interpretation of the duty to warn's underlying purpose in protecting patient autonomy. Essentially, the assertion made by Wallace was that had Kam acted in accordance with his duty by disclosing all material risks, he would have exercised his autonomy in a way that would have declined the procedure and avoided exposure to the harm (neurapraxia) in question.³⁰¹ The influence of *Chester*'s type of reasoning is evident in Justice of Appeal Beazley's dissenting Court of Appeal judgment in *Wallace*,³⁰² and it was open to the Australian High Court to adopt a similar line of reasoning and thus engage in a broader analysis of the issues relevant, under scope of liability, to a patient's decision to consent to a procedure that carries multiple risks. Clearly the High Court did not wish to prioritise the notion of patient autonomy in the same way that the concept was directly emphasised by the House of Lords in *Chester*. Rather, as discussed in Part IV(B), the Court took a restrictive view of the form of harm falling 'within the scope of the rule violated by the defendant'³⁰³ by adopting only the first, or narrower, purpose of the duty to warn advocated by Lord Steyn.³⁰⁴ Consequently, as a matter of policy and by comparison to English law, the High Court has, by virtue of its approach to the issue in *Wallace*, unfortunately adopted a more diluted attitude to the protection of patient autonomy in failure to warn cases.

299 See above nn 67–9, 85–91, 227 and accompanying text.

300 The House of Lords is no longer the highest appeal court in England and Wales, having been replaced in this role by the Supreme Court of the United Kingdom on 1 October 2009.

301 See, eg, Ian Wallace, 'Appellant's Amended Submissions', Submission in *Wallace v Kam*, S307/2012, 1 November 2012, [4], [41]; *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 051 [39] (Beazley JA), 66 068 [157] (Basten JA).

302 As discussed above n 73 and accompanying text, her Honour considered that:

the causation question has to be determined having regard to the content of the duty, namely a duty to warn of material risks. Accordingly, where there is more than one material risk, and a finding is made that a plaintiff would not have undergone surgery if warned of other material risks, it is difficult to see reasons in logic or policy why a negligent doctor should not be liable notwithstanding that a different risk eventuated: *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 067 [148].

303 *Chester* [2005] 1 AC 134, 162 (Lord Hope).

304 Namely, 'to avoid the occurrence of the particular physical injury the risk of which a patient is not prepared to accept': *Chester* [2005] 1 AC 134, 144. See above nn 281, 290 and accompanying text.

VI CONCLUSION

In terms of scope of liability, the courts' decisions in *Wallace* reflect a policy choice that, in failure to warn cases, liability *ought* only to attach to *physical injury* the *risk of which was unacceptable* to the patient. It is the product of a value judgment or a line drawing exercise as to the extent of a medical practitioner's liability, and by limiting negligence liability in this way the decision is likely to be welcomed by the profession and its insurers. For, as stated by the High Court, that choice, now made, will be 'maintained unless confronted and overruled'.³⁰⁵ Meanwhile, as *Chester* shows,³⁰⁶ a tempering of causation principles is possible where justice demands it. A determination of the acceptability of a risk and accordingly whether a failure to warn is causative, within the framework provided by this article, will depend to a large extent upon the nature and categorisation of the risk in question, and this may in the future prove contentious and problematic. The High Court did not query the classification of the risks in *Wallace* as being distinct rather than cumulative, although the Court of Appeal did confirm that such a classification, for the purpose of scope of liability under sections 5D(1)(b) and (4) of the *Civil Liability Act 2002* (NSW) (and the equivalent provisions in other jurisdictions),³⁰⁷ would need to occur on the facts of any given case.³⁰⁸ When this does transpire, it is therefore hoped that as wide an interpretation as possible is preferred, as arguably such an approach is better aligned with how patients actually make decisions. It is additionally more respectful of the autonomy of patients, which the law in this area is intended to reinforce.

305 *Wallace v Kam* (2013) 250 CLR 375, 385 (French CJ, Crennan, Kiefel, Gageler and Keane JJ). See also *Neville v Lam [No 3]* [2014] NSWSC 607, [174] (Beech-Jones J).

306 Discussed above Part V.

307 See above n 25.

308 *Wallace v Kam* [2012] Aust Torts Reports ¶82–101, 66 050 [30] (Allsop P).