High Court warns of the 'retroscope' in informed consent cases: *Rosenberg v. Percival*

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Hindsight is a powerful influence in the instigation of informed consent cases. However, what patients think after the event is not the issue when assessing their claims: it is what they thought when they agreed to the treatment that matters.

Some doctors have been concerned that the law on 'informed consent' makes it too easy for patients to sue if something goes wrong in a medical procedure. Even if the doctor has performed a procedure with due care and skill, the patient may sue because the doctor did not disclose a 'material' risk that later eventuated. Patients may allege that they would not have agreed to the procedure if told about the risk, and that the doctor's negligent failure to inform about the risk therefore caused the injury or loss that they have suffered (see box on page 80).

These concerns may be allayed to some extent by the recent decision of the High Court of Australia in *Rosenberg v. Percival* (2001).[1] All judges were clearly aware of the dangers of the 'retroscope' in deciding whether a patient would have acted differently if fully informed about the risk in question. This is evident from the comments quoted below. The judges unanimously rejected the patient's insistent claims that she would not have agreed to undertake surgery (that she clearly needed) if she had been warned of the remote risk that ultimately eventuated, and she subsequently lost the case.

The facts

The patient, Dr Percival, was 42 years old when she consulted Mr Rosenberg, an oral and maxillofacial surgeon, about her worsening malocclusion. He recommended an osteotomy but did not mention the risk of temperomandibular joint (TMJ) disorder.

After surgery, the patient had persistent pain, could not speak loudly or eat hard food, had muscle spasms, needed psychiatric treatment, and had reduced earning capacity.

She alleged that the surgeon had been negligent in failing to warn her of the risk of TMJ disorder and that, if she had been informed about that risk, she would not have undertaken the surgery.

The issues

There were two main issues in the case. The first was materiality: was the risk a 'material' risk within the test stated in *Rogers v Whitaker* (1992), so that it had to be disclosed to the patient?[2] The second issue was causation: did the surgeon's failure to mention the risk 'cause' the patient's injury?

In other words, would the patient have refused the surgery if warned of the risk, and so avoided the injury; or would she have agreed to undertake the surgery even if she had been warned of the risk?

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The judgments

Only two judges ruled on the first issue of materiality. Kirby J said, as had the Western Australia Full Court, that the risk was material and should have been disclosed. The risk was known in the profession and the patient 'gave attention to detail [and] stressed that she wanted her dental occlusion to be properly attended to' (*Rosenberg* paras 147, 150).

Gummow J, on the other hand, said that the risk was not material so the surgeon was not negligent in not disclosing it. He said that the issue in *Rosenberg* was not what he called the 'subjective limb' of the *Rogers* test – that is, whether the doctor should have known that the particular patient would have been likely to attach significance to the risk. This was the issue in *Rogers* and *Chappel v. Hart* (1998) where the respective patients had asked so many questions that a doctor taking reasonable care should have known that the risks in question were material for those patients (*Rosenberg* para 76).[2,3] In *Rosenberg*, the issue arose from the 'objective limb' of the test – would an ordinary person in the patient's position have considered the risk material? (*Rosenberg* para 76.)

Gummow J's reasons included the fact that '[the patient] did not ask questions identifying a particular area of concern and there [was] no indication of any relevant physical or mental characteristics [of hers] of which [the surgeon] should have been aware… the osteotomy was the most effective way to remedy [her occlusion]… [the patient] was an experienced and knowledgeable nurse who was certainly aware that all surgery carried some risk and… [she] had received advice from a number of sources indicating that she should proceed with the judgment' (*Rosenberg* para 81).

All the judges, however, agreed on the second issue of causation: they all held that the patient should fail because she had not proved causation. This is the most important aspect of the judgment. They all said that the test for determining causation is subjective – what would the particular patient have done if she had been told of the risk of TMJ disorder? They also acknowledged the self-serving nature of the patient's testimony in this regard and warned that it should be carefully scrutinised. In relation to Dr Percival, the following factors were taken into account.

- She was an experienced nurse – she had been nursing for 20 years and had a PhD in nursing. She knew that surgery carries risks and was willing to take the risks of a general anaesthetic with which she was familiar from her professional experience.

Informed consent

Although the term 'informed consent' is common in the medical literature, the High Court of Australia said in para 490 of *Rogers v. Whitaker* (1992) that the term is 'apt to mislead as it suggests a test of the validity of the patient's consent' and 'consent is relevant to actions framed in trespass [which are rare in a medical context in Australia], not in negligence [the usual cause of action in failure to inform cases in Australia]'.[2] Instead, one should talk about a doctor's duty in the law of negligence to take reasonable care in providing information to patients.

Many concerns about the rule in Rogers are neatly summarised by Kirby J in para 143 of Rosenberg v. Percival (2001).3 His responses concerning the general duty to inform (Rosenberg para 145) are also of interest.

- She did not ask specific questions about risk. However, as Kirby J said, the doctor's duty to inform is 'not dependent on questions asked by the patient who might be completely unaware of the issues to which his or her mind should be addressed' (*Rosenberg* para 141).
- More importantly, she had a worsening condition that clearly needed treatment. She consulted several specialists to get the best results. Osteotomy is an appropriate treatment in such cases and the risk of harm is small. The risk of TMJ disorder in particular was very slight and, according to Gummow J (*Rosenberg* para 70), 'the literature [in 1993] was equivocal as to the likelihood and the possible severity of [TMJ] complications'. An expert witness, Professor Goss, testified that he had seen two cases in the last decade in addition to Dr Percival where an osteotomy had aggravated a pre-existing TMJ condition and the patients ended up with severe TMJ problems (quoted by Callinan J, *Rosenberg* para 179). Professor Goss assessed the risk of severe chronic pain from TMJ disorder as between 1:2500 and 1:6000 (*Rosenberg* para 180). Four of the expert witnesses said that they would warn about TMJ problems. One, in addition to Mr Rosenberg, said that they would not give a specific warning (*Rosenberg* paras 186 to 191).
- She was willing to have a second operation to alleviate pain after the first one so she was not averse to surgery as a general principle.

For all these reasons, the patient's allegation that she would not have agreed to the osteotomy if informed of the risk of TMJ was rejected. Note also that the reasons listed as being relevant to the issue of causation were also relevant to whether the risk was material and had to be mentioned (see the comments of Gummow J quoted above).

Even more significant, however, are the judges' comments concerning the patient's assertions that she would have refused surgery if informed of the risk that eventuated. Chief Justice Gleeson said (emphasis added), 'In the way in which litigation proceeds, the conduct of the parties is seen through the *prism of hindsight*. A foreseeable risk has eventuated, and harm has resulted. The particular risk has become the focus of attention. But at the time of the allegedly tortious conduct, there may have been no reason to single it out from a number of adverse contingencies, or to attach to it the significance it later assumed.' (*Rosenberg* para 16.)

He also said (in the same paragraph) that one should take account of 'the context, before or at the time of the event' in evaluating the likely impact of a particular contingency on the patient's decision to proceed; and 'whether there were, at the time, strong reasons in favour of pursuing the [surgery in question]'.

In similar vein, Kirby J noted 'the self-serving character' of the patient's evidence of 'what, hypothetically, [she might have done] had she been properly warned of the risks of osteotomy' (*Rosenberg* para 109). He quoted the trial judge's observation that '[T]he answer is one that would be expected in the circumstances and of course, again in the circumstances [is] of no evidentiary value whatsoever' (*Rosenberg* para 129). Later he said that 'the court should assess the patient's testimony [about what she would have done if warned of the risk] carefully' (emphasis added), 'If a *reasonable person* would have undergone treatment regardless of disclosure, then in the absence of

personal characteristics or circumstances which would explain a refusal, it must be difficult for a court to conclude that the [patient] would have rejected the treatment no matter what the [patient] now genuinely believes that he or she would have done.' (*Rosenberg* para 158.)

Conclusion

In conclusion, this means that, despite the test for causation being subjective, the court will still take account of what a reasonable person would have done in assessing the patient's testimony and deciding whether it is to be accepted. This approach will make it harder for patients to win informed consent cases, especially where surgery was clearly needed.

Series Editor's comment

As Professor Skene points out, use of the term 'informed consent', or more particularly, 'failure of informed consent', is inappropriate. 'Informed decision making' is a more accurate description of the process that respects a patient's autonomy and right of self-determination. There is endless dispute in hospitals about 'consent' forms, specifically over who has the burden to see they are appropriately detailed and signed. The American film producer Louis Mayer once said 'A verbal contract ain't worth the paper it's written on!' A signed consent form ain't worth much more. Yes, it will protect against an accusation of assault or battery, in that a signed consent form indicates what type of procedure the patient has consented to, but the bit of paper is not proof that the consent obtained was informed.

'Informed decision making' is a matter for the patient. The doctor 'discloses' to each patient, first, the information any 'reasonable person' in the position of the patient would think relevant in deciding whether or not to take the doctor's advice and, second, the additional information any 'reasonable doctor' would add in the knowledge of the circumstances of that particular patient. The 'reasonable patient' test is what the High Court in *Rogers* called the 'objective' test. The 'reasonable doctor' or 'individual patient' test is what the High Court called the 'subjective' test. Looked at that way, when patients sue for damages arising from 'failure of informed consent' the negligence asserted is better described by the term popularly used in the USA – 'disclosure malpractice' – because that is what the doctor does or does not do.

To be successful in litigation, the plaintiff must prove that:

- the defendant owed the plaintiff a 'duty of care'
- the defendant breached that duty of care (i.e. was 'negligent')
- the plaintiff suffered a damage
- the defendant's negligence caused the damage.

Just proving disclosure malpractice does not entitle a patient to damages – that is the message reinforced by *Rosenberg v. Percival*. It is not a new message. In *Petrunic v. Barnes* (1988), Tadgell JA, in the Supreme Court of Victoria, outlined the same causation argument reinforced in *Rosenberg* over 12 years later.[4]

What does this mean in clinical practice?

Sometimes patients are so fixated on their expectations of a particular treatment that they fail to give proper consideration to information provided.

This is a common situation with patients who request cosmetic procedures. Some of these patients, who have clearly been properly informed about possible risks, are so determined to have the procedure, often with unrealistic expectations, that they only have second thoughts when, for example, a wound infection has led to worse than anticipated scarring. It is then easy to assert, 'If I had known I could end up looking like this, I would never have agreed to have the procedure.' This is exactly where *Rosenberg* comes in. What the *Rosenberg* decision says is that what the patient thinks now is not relevant in assessing their claim. It is what they thought when they were making up their mind about the requested or suggested treatment that matters.

GPs should not think all this only applies to procedural specialists: the same principles apply to the advice given by any doctor to any patient about any suggested treatment or diagnostic procedure.

Rogers represented the High Court's endorsement of a move away from medical paternalism. In the 1920s and 1930s, the Dr Findlays of the world saw it as their heavy burden to make wise decisions for their patients. In the latter half of the twentieth century, and certainly in the twenty-first century, it is our heavy burden to help our patients make properly informed decisions. Whether those decisions are 'wise' is none of our business. Obviously, we want our patients to follow our advice (and we are concerned for them when they do not), but our business is to provide proper advice backed up by disclosure of sufficient information for the patient to evaluate that advice.

Rosenberg tilts the balance back a bit. By underscoring the need to prove causation when damages are claimed for disclosure malpractice, the High Court is saying that patients must accept responsibility for their own decisions – if those decisions were properly informed.

Doctors disclose. Patients decide. MT

References

1. *Rosenberg v. Percival* (2001) High Court of Australia 18.
2. *Rogers v. Whitaker* (1992) 175 Commonwealth Law Reports 479.
3. *Chappel v. Hart* (1998) 195 Commonwealth Law Reports 232.
4. *Petrunic v. Barnes* (1988) Australian Torts Reports, 80-147.