Rogers v Whitaker: still crazy after all these years?

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Introduction
The year 2007 marks the 15th anniversary of the landmark Rogers v Whitaker case, a watershed in Australian medico-legal history. When the decision was handed down in 1992, it caused a stir in the medical and associated health professions over the shift in emphasis from the standard of a reasonable doctor to that of a reasonable patient in terms of information provided to patients on risks associated with medical procedures. Further, it is a case with which Health Information Managers (HIMs) should be familiar.

The case
The facts of the case are almost as well known to health professionals as the impact of the decision. When Mrs Whitaker was a young girl she suffered a penetrating eye injury which left her almost totally blind in her right eye. When she was in early middle age she was referred to an ophthalmologist, Dr Rogers, who advised her that he could clear up some of the scarring over her eye, which would improve both her sight and the aesthetic appearance of the eye.

Mrs Whitaker was very nervous about having the surgery and asked many questions about the nature of the operation. Her questions mostly went to the issue of any mistake that could be made through operating on her good eye. Dr Rogers assured her on this point and they even agreed to the placing of a bandage over her good eye so as to avoid this occurring. The operation went ahead as planned but unfortunately, as a result of the operation, Mrs Whitaker suffered a condition known as sympathetic ophthalmia and was left virtually completely blind in both eyes.

It is important to note that the operation, as performed by Dr Rogers, was conducted technically perfectly. Sympathetic ophthalmia is type of uveitis caused by a perforating wound of the uvea followed by a similar severe reaction in the other eye that may lead to blindness in both eyes. It is fundamentally an immunological disorder, the triggering of which, in Mrs Whitaker's situation, was caused through correct surgical technique. The probability of sympathetic ophthalmia occurring in Mrs Whitaker's case was estimated to be a chance of one in 14,000 (an extraordinarily remote figure in medical probabilities).

Mrs Whitaker sued Dr Rogers for failing to warn her of the possibility that she may develop this condition as a result of her surgery. Mrs Whitaker claimed that had she known of such a possibility (remote as it was) that she would never have agreed to the surgery. The New South Wales Supreme Court (Rogers v Whitaker, 1991) found in her favour and awarded her just over $800,000 in compensation. The NSW Court of Appeal dismissed Dr Rogers' appeal, a decision which was affirmed by the High Court (Rogers v Whitaker, 1992). That is, Dr Rogers should have warned Mrs Whitaker that by undergoing the surgery there was a slight, but real, risk of her developing sympathetic ophthalmia, which could leave her permanently blind. Whether knowledge of such a risk would really have affected Mrs Whitaker's decision is moot. Mrs Whitaker claimed that her pre-existing blindness in one eye made her all the more sensitive to anything adverse happening to her good eye.

Dr Rogers, as one might expect, was especially sympathetic for Mrs Whitaker's outcome, acknowledging that, short of death under anaesthetic, this was the worst possible result that could have occurred. Incidentally, Dr Rogers later described himself as especially sensitive about the case, successfully suing the Daily Telegraph when they defamed him by alleging that it was his negligent skill that caused Mrs Whitaker's blindness (Rogers v Nationwide News Pty Ltd, 2003).

Why the case is a landmark judgment
Rogers is important because it is the reference point for a number of essential elements in
medico-legal practice. Four important points to know about Rogers are:
1. It is used as a reference point for the definition of the standard of care owed by a doctor to a patient.
2. It overturned the Bolam principle in failure to warn cases.
3. It defined what a material risk is.
4. It declared that if an action is brought in failure to warn, it must be done so in negligence, not in trespass.

1. Standard of care

That a doctor owes a duty of care to his or her patients is indisputable. Rogers defined the range of issues which that duty covered (at 483):

The law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a ‘single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment’ (quoting Lord Diplock in Sidaway v Governors of Bethlem Royal Hospital, 1985); it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case (referencing Gover v South Australia, 1985).

In determining whether a doctor has breached that duty of care, his or her actions must be measured in terms of whether they have met a particular standard of care. Given that a doctor’s work involves special skill, as distinct from an ordinary member of the public who may owe a duty of care to another, the doctor’s standard (in the course of doing his/her work) is higher. The High Court majority defined the standard (at 483) in Rogers:

The standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill, in this case the skill of an ophthalmic surgeon specializing in corneal and anterior segment surgery.

This extract references, amongst others, an English case, Bolam v Friern Hospital Management Committee (1957), where McNair J, in a well known passage, distinguishes the above standard for the ‘medical man’ (sic) with that expected of ‘the man on top of the Clapham omnibus’ (that is, the ordinary man). From the same case came the authority for how the standard is measured.

2. The Bolam Principle

The most well known aspect of the Rogers case is that the Bolam principle was overturned in ‘failure to warn’ cases. The Bolam principle gets its name from the seminal English case, Bolam v Friern Hospital Management Committee (1957), in which McNair J gave a jury instruction in the following terms (at 587):

A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art.

The principle had been used widely in England including, as recently as 1985, when it was applied in Sidaway v Governors of Bethlem Royal Hospital (1985). Lord Scarman, in dissent in that case, rejected its use, but restated it as follows (at 881):

The Bolam principle may be formulated as a rule that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even though other doctors adopt a different practice. In short, the law imposes the duty of care: but the standard of care is a matter of medical judgment.

The Bolam principle may be seen as the ‘reasonable doctor’ standard – what would the reasonable doctor disclose to the patient?

This was the essential issue on appeal in Rogers. Dr Rogers brought a number of experts in the field who testified that they, too, would not have thought to warn Mrs Whitaker about a risk as remote as that of sympathetic ophthalmia, only more common risks such as retinal detachment and haemorrhage infection. On Mrs Whitaker’s side there was a similarly respected body of opinion who gave evidence that they would have warned of the risk of sympathetic ophthalmia, not least of which was because it was the only condition which might lead to her becoming totally blind.

Dr Rogers’ counsel relied on the Bolam principle, pointing to the existence of two responsible bodies of medical opinion. Under Bolam, for Dr Rogers to have been found negligent, he would need to have acted in a way that no
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competent practitioner would. Just because there is a different body of responsible opinion, Dr Rogers claimed that he should not be considered negligent, as he acted in accordance with a responsible body of opinion, unless the trial judge finds that the practice is not responsible. Central to some of the opinions from Dr Rogers’ experts was that, while Mrs Whitaker asked incessantly about many aspects of what could go wrong in the operation, she did not specifically ask whether by operating on her right eye, something could happen to her left eye. On this point particularly, the majority justices were unimpressed, stating that ‘it demonstrates vividly the dangers of applying the Bolam principle in the area of advice and information’ (at 491), as it required the patient to be ‘sufficiently learned to ask the precise question’.

In the previous decade, lower Australian courts had, like Lord Scarman, become similarly dissatisfied in applying the Bolam principle, especially in ‘failure to warn’ cases (for example, F v R, 1983). In Rogers, for the first time, the High Court heard the issue and rejected the Bolam principle along with Dr Rogers’ argument. The majority opinion felt that the determination of whether a doctor had breached a duty of care to his/her patient in not warning of a particular risk was ultimately one for the court to decide, not the medical profession. While the opinions of the medical profession may be considered and in many cases would be useful, they were not to be determinative.

The court in Rogers agreed with the leading Canadian authority, Reibl v Hughes (1980), which felt that allowing doctors to determine what risks were and were not significant or ‘material’ to the patient, would ‘hand over to the medical profession the entire scope of the duty of disclosure, including the question whether there has been a breach of that duty’ (at 894). A patient has the right to make up their own mind as to whether they wish to proceed with an operation, having received proper and full advice and information about the material risks of the procedure, not that which a doctor may decide to tell the patient. The majority justices did qualify the move to a reasonable patient standard as being subject to the therapeutic privilege, but for our purposes this need only be mentioned rather than explored in detail.

3 Definition of ‘material risk’
If the Bolam principle was to be rejected, then clearly it had to be replaced with a different standard. Many superior appellate courts in other Western common law jurisdictions had grappled with this concept. The United States (Canterbury v Spence, 1972) and Canada (Reibl v Hughes, 1980) had both brought down landmark judgments where a ‘patient-oriented’ determination of risk was used.

In replacing Bolam, the High Court drew upon the North American decisions and decided that in Australia, the law should recognise that patients should be warned of a material risk. The majority opinion defined a material risk in the following terms (at 490):

[A] risk is 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 …

This is as far as the courts in the United States and Canada went: an objective test. That is, a risk to which a reasonable patient would attach significance. In this way, the High Court’s formulation provides a different emphasis to that of the Bolam principle, as it asks what the reasonable patient would want to know, rather than that which the reasonable doctor would feel it necessary to disclose. However, the High Court went further and followed the objective arm of the ‘material risk’ test with a second ‘subjective’ arm (at 490):

…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.

The subjective arm asks the doctor to consider not only what risk a ‘reasonable’ patient would deem to be significant, but also what risks the ‘particular’ patient they are treating, would deem to be significant.

Therefore, risks which are not only inherent in the proposed procedure need disclosure, but also risks which are particular to the patient. An example may be that a patient with severe diabetes contemplating undergoing a foot operation should be told about the risk of failure
Reports

4 Negligence, not trespass

The fourth main point decided in Rogers has perhaps the least impact for Health Information Managers (HIMs), however, it is a key issue in health care, so it is of interest to cover briefly here. The High Court finally put to bed the issue of the validity of consent for an operation.

The tortious act of trespass to the person is caused through the least amount of intentional physical contact from one person to another. Trespass to the person (as distinct from trespass to land or to goods) stems from the founding principle that each person's body is inviolate and that the least amount of unwanted touching founds an action, known as a ‘battery’. Doctors and other health care professionals have no special dispensation in terms of touching a patient (outside the sphere of emergencies). Therefore, the patient’s consent must be gained prior to any physical contact, from the simplest examination to a full surgical procedure. Consent by a patient does not have to be written, it may be given orally or even impliedly (holding one’s arm out to receive an injection is the commonly quoted example), however, all state health departments have as their prudent policy that all non-emergency surgical procedures must be preceded by written consent.

In terms of bringing an action in trespass arising from a failure to warn in a doctor-patient relationship, the argument goes along the following lines: If a patient’s consent is required to vitiate an action in trespass and the patient is not fully informed about the associated risks to the procedure, the patient has, in fact, not consented at all to the procedure and thereby they have a claim for battery (trespass) against the doctor. The importance of this argument is in its effect – trespass is ‘actionable per se’, meaning that the plaintiff does not have to show that damage was caused by the defendant, merely that the action itself was done (that is, the physical contact). This is generally easier to prove than actions in negligence where the plaintiff must prove that damage resulted (not too remotely) from the defendant’s action or lack thereof.

The High Court in Rogers eschewed the ‘amorphous phrase “informed consent”’ (at 490), declaring that it was apt to mislead. They held what was at issue here was not the validity of the patient’s consent – Mrs Whitaker knew what the mechanics of the operation were and agreed to have it performed – but a failure on the part of the doctor to adequately inform the patient of the risks associated with the procedure. They declared that ‘…the consent necessary to negative the offence of battery is satisfied by the patient being advised in broad terms of the nature of the procedure to be performed’ (at 490).

Thus, so long as the patient is told ‘in broad terms’ of what the operation involves, the patient’s subsequent consent is valid. That is, if a doctor tells his/her patient that they will remove the appendix and do so, even though complications result from this, the patient has no action in trespass. If, on the other hand the gallbladder is removed by mistake, the patient will have an action in trespass, as this was not consented to. By so holding, the High Court conclusively determined that if a patient wishes to bring a failure to warn case against a doctor, they must frame their action in negligence, not in trespass.

Criticisms of Rogers

Criticisms were made of the High Court’s decision in Rogers almost immediately. Initially, this came from doctors who objected to the use of the ‘reasonable patient’ standard in favour of the ‘reasonable doctor’ standard. Many doctors were confused about the scope of the warnings which they had to provide to their patients – would a doctor have to warn of every conceivable risk that could possibly eventuate, and if he/she inadverently did not, and the risk did occur, would this provide grounds for being sued? Would warning
a patient about the risk of death associated with surgical intervention, or reaction to the anaesthetic, upset patients enough to prevent them from going into surgery (Skene 2002)?

Some of the criticisms appeared fixed in an old-fashioned mindset of doctors’ and patients’ respective roles and could be considered rather shrill (Arnold, 1994). However, many other clinicians accepted that a reasonable patient standard was inevitable and justified.

In Australia, in the years since the Rogers case, the subjective arm of the material risk definition received its high water mark reading in Chappell v Hart (1998) where the court believed a patient who stated that she would not have gone through with necessary throat surgery, at that time, had she been warned of the possibility that an infection resulting from the random chance that bacteria already present at the operation site could perforate through the oesophagus to the mediastinum and subsequently affect her vocal cords (a possibility which, in fact, eventuated).

This led to a re-examination of self-serving, retrospective statements from patients who have the benefit of hindsight in making their claims. Many other doctors accepted that a reasonable patient standard was inevitable and justified.

In the American case, Canterbury v Spence (1972), were particularly wary of this consequence, and therefore did not include the subjective arm in their reasonable patient test.

Finally, with the High Court decision in Rosenberg v Percival (2001) the tide began to recede. Here, the patient claimed that she would not have gone through with an elective sagittal split osteotomy had she been warned of the very small risk of temporomandibular joint disorder resulting from the operation. The High Court found against the patient and reversed an initially favourable Supreme Court of Western Australia decision.

Why HIMs need to know about Rogers

- Rogers is the most famous medico-legal case in Australia (certainly of the past 25 years) and any HIM working in the medico-legal area should have a sound understanding of its implications, as it is well known, if not well-regarded, by all health professionals, especially doctors.
- HIMs are the health professionals with primary responsibility for, and expertise in, medical record documentation. As such, HIMs are often called upon and are in a unique position to inform and educate our colleagues in the other health professions of their responsibilities, as well as strategies they may use to comply with their legal obligations.

When a clinician has had a conversation with a patient about the risks associated with a proposed procedure, it is then essential that they provided clear documentation of the discussion of risks that took place. Primarily, this is for coverage in the case of any legal claim which may follow; it will hold little clinical significance for ongoing care or communication purposes, although there may be situations where these may be relevant, especially in the case of psychological factors.

The importance of such clear documentation in a medico-legal context should be stressed to clinicians providing advice about the risks associated with the procedure. Generally, when a court considers the evidence before it, in the absence of clear documentation from the clinician, the court is more likely to give greater credence to the patient’s recollection of events, rather than that of the clinician. This is because, for the patient, the operation they underwent would have been a major experience in their lives – a seminal event – of which they would have a far clearer memory than a doctor who conducts many of these operations, and sees many different patients with the same condition. (There are some doctors who claim that they can recall, in detail, every conversation they have had with every patient whom they have seen in their rooms. By and large, these individuals' testimonies are not believed by the courts!) It is to be noted that this reasoning holds only when the patient’s and the clinician’s respective testimonies are similarly credible.

Good medical record documentation in general should show a clear path from the patient’s presentation of symptoms and clinical investigation, through diagnosis to procedural options and ultimate treatment. Clinicians should be in the habit of documenting the discussion surrounding disclosure of risks of a procedure, in particular,
including any questions the patient has, and the answers that were given.

A standard paragraph on an operation report to the effect that ‘the patient was assessed as suitable for the procedure and had all the risks inherent in the treatment explained to them and agreed to proceed with the operation’ is inadequate and unsuitable. A clear distinction should be made between each individual patient, the precise risks they were told about, even if, in each case, they are the same. Any questions the patient asks should also be documented. Ideally, in the absence of any questions from the patient, a note in the record should be made to this effect.

Many HIMs have the responsibility for hospital forms and their design. These HIMs should consider what information or prompts any operative consent form should contain and how such a form should be laid out. Should the hospital or health care organisation have separate consent forms for different types of procedure? If so, are these forms able to outline all the risks inherent for a particular procedure? Does it have to? How detailed should these be? How certain should a doctor be that a patient understands the risks? What can a doctor do to ensure, as far as possible, that the patient does comprehend and accept the risks that have been explained?

The answers to these questions will depend greatly upon local procedural considerations and will most likely require consultation with local clinical bodies and state agency branches – many of which have issued their own standard consent forms. HIMs have a responsibility for informing themselves adequately of the issues involved in risk documentation so that they may become a valuable part of such a consultative process.

**Still crazy?**

After all these years, is the decision in Rogers v Whitaker fundamentally flawed or fundamentally sound?

The decision’s main achievement was to realign a balance of power in favour of the patient through its rejection of the Bolam principle and, in so doing, has made considerable progress in recognising individual patient autonomy in health care (Rosenberg v Percival 2001: 480). It insists upon minimum legal obligations, which almost certainly have served to ensure patients are better informed as a result of the decision than they likely were prior to it. Doctors are now wary to ensure that, in the normal course of events, they have included as much information as they can about the risks associated with a procedure and recognise the importance of listening to a patient’s questioning and answering fully and frankly.

There is no evidence to suggest that, as a result of risk disclosure brought about by the Rogers decision, patients are refusing surgery when they hear of the risks of death or disability associated with any given procedure. Nor is there any evidence to suggest that Rogers has made failure to warn cases easier for plaintiffs.

For HIMs involved in the medico-legal field, knowledge of Rogers and consultation with clinicians about their responsibilities arising from it brings about an opportunity to build relationships as well as a good chance to encourage good documentation.

**References**

**Cases**

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**Journal articles**


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