DISCLOSURE OF MATERIAL RISK AS SYSTEMS-ERROR TRAGEDY:
WALLACE v KAM (2013) 87 ALJR 648; [2013] HCA 19

The law requiring a patient to be informed not just of the nature of a medical procedure but also its likely but subjectively significant risks, which blazed across the southerly firmament of patients’ rights in 1992 with the decision of Rogers v Whitaker (1992) 175 CLR 479, appears to have now passed to the outer darkness of judicial deference. The decision of the Australian High Court in Wallace v Kam (2013) 87 ALJR 648; [2013] HCA 19 continues the judicial trend to go cool on patients’ rights and restrict the capacity of medically injured people to claim redress which was evident in Rosenberg v Percival (2001) 205 CLR 434 and various Australian State civil claims statutes. This trend only heightens the analogy between the law of informed consent and classical literary tragedy. Indeed, heightening the analogy between the legislation and case law on disclosure of material risk and classical literary tragedy may provide necessary insights to bring greater justice to patients injured as a result of medical misadventure and incompetence.

INTRODUCTION

It has long been intriguing how medico-legal cases on disclosure of material risk somehow resonate with the forms and structures of classical literary tragedy as notably dissected by Aristotle in his Poetics, honed by Sophocles in works such as Oedipus Rex, and brought to perfection by Shakespeare in late plays such as King Lear, Hamlet, Macbeth, Anthony and Cleopatra and Othello. This is not, as might be supposed, because it is relatively easy to suppose that the judges involved are unconsciously drawing upon sound classical educations in shaping their opinions. Alas, the days of judicial polymath illuminati incrementally heightening legislative and constitutional resonance with fundamental patterns of harmony (known normatively as foundational social virtues such as justice, equity and environmental sustainability) appear to have gone.

Rather, the argument here is that, just as many branches of science proceed by generating hypotheses out of analogies, so the area of what is known most popularly as “informed consent”, but also as “disclosure of material risk”, may benefit from comparison with classical literary tragedy. The High Court decision of Wallace v Kam (2013) 87 ALJR 648; [2013] HCA 19, on appeal from the New South Wales Court of Appeal, is used to illustrate why such an approach may be useful.

The facts were that in 2004 the patient, Mr Wallace, consulted Dr Kam, a neurosurgeon, to perform a fusion on his lumbar vertebrae. The aim was to alleviate pain caused by a protruding intervertebral disc. The operation was not successful in relieving the back pain. Mr Wallace developed temporary local damage to nerves within his thighs, described as “bilateral femoral neurapraxia”, resulting from lying face down on the operating table for an extended period. In Wallace v Ramsay Health Care Ltd [2010] NSWSC 518 Harrison J, at first instance in the New South Wales Supreme Court, found that Mr Wallace, all those years ago, had not received any warning concerning material risk, but that, even if he had, he would have let it pass and still have had the operation, in spite of all the danger. Harrison J held that although Dr Kam had breached his duty to the patient in failing to disclose the material risk of neurapraxia, that failure could not causally be related to the damage the patient suffered and so was not actionable in the tort of negligence.
Mr Wallace also claimed he had not been informed by Dr Kam of the one-in-20 chance of permanent and catastrophic paralysis resulting from damage to his spinal nerves, but that if he had been, he would not have undergone the operation and so not sustained the neurapraxial damage. Harrison J declined to make any finding about whether Dr Kam negligently failed to warn Mr Wallace of the risk of paralysis, and about what Mr Wallace would have done if warned of such risk, on the basis that the “legal cause” of the neurapaxia “could never be the failure to warn of some other risk that did not materialise” (at [96]).

Mr Wallace appealed to the Court of Appeal of the Supreme Court of New South Wales in Wallace v Kam (2012) Aust Torts Reports 82-101 (Allsop P, Beazley and Basten JJJA), arguing that Harrison J erred in holding that the legal cause of the neuraxxia could not be the failure to warn of the risk of paralysis. In the Court of Appeal, the majority (Allsop P and Basten JA) dismissed the appeal, although Beazley JA would have ordered a new trial.

The Australian High Court unanimously (French CJ, Crennan, Kiefel, Gageler and Keane JJ) agreed with the majority of the Court of Appeal and dismissed Mr Wallace’s appeal.

THE AUSTRALIAN HIGH COURT AND THE MEDICAL DUTY TO DISCLOSE MATERIAL RISK PRIOR TO AN OPERATION

The Australian High Court in Wallace v Kam (2013) 87 ALJR 648; [2013] HCA 19 reiterated (at [8]) the Rogers v Whitaker (1992) 175 CLR 479 creed that:

The common law duty of a medical practitioner to a patient is a single comprehensive duty to exercise reasonable care and skill in the provision of professional advice and treatment [at 489]. A component of that single comprehensive duty is ordinarily to warn the patient of “material risks” of physical injury inherent in a proposed treatment [at 490].[1] A risk of physical injury inherent in a proposed treatment is material if it is a risk to which a reasonable person in the position of the patient would be likely to attach significance, or if it is a risk to which the medical practitioner knows or ought reasonably to know the particular patient would be likely to attach significance in choosing whether or not to undergo a proposed treatment [at 490]. The component of the duty of a medical practitioner that ordinarily requires the medical practitioner to inform the patient of material risks of physical injury inherent in a proposed treatment is founded on the underlying common law right of the patient to choose whether or not to undergo a proposed treatment. In imposing that component of the duty, the common law recognises not only the right of the patient to choose but the need for the patient to be adequately informed in order to make that choice rationally. The policy underlying the imposition of that component of the duty is to equip the patient with information relevant to the choice that is the patient’s to make [at 486, 488-490]. The duty to inform the patient of inherent material risks is 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”.[2]

The common law duty of a medical practitioner is therefore ordinarily breached where the medical practitioner fails to exercise reasonable care and skill to warn a patient of any material risk of physical injury inherent in a proposed treatment.

This reiteration of a doctor’s duty to provide reasonable care is consistent with key common law cases in many jurisdictions. It creates an obligation to provide relevant information as to the dangers and consequences, the material risks, of a proposed treatment or procedure.[3] The two well-known exceptions are:

- common law necessity (emergency) (necessary to save the patient from immediate risk of substantial harm); and
- therapeutic privilege (information that would harm the patient, not merely make the patient anxious).

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1 See also Rosenberg v Percival (2001) 205 CLR 434 at [61].
2 Quoting Chester v Afshar [2005] 1 AC 134 at [18].
3 Sidaway v Board of Governors of the Bethlem Royal Hospital and the Maudsley Hospital [1985] AC 871; Canterbury v Spence 464 F 2d 772 (1972); Reibl v Hughes (1980) 114 DLR (3d) 1.
Such cases require the plaintiff not only to establish breach of duty of care, but also that a distinct injury was caused by the doctor’s failure to disclose material risk information. The patient’s barrister will have contended that, if only the plaintiff had known all the facts, he or she would not have gone ahead with the operation, or would have delayed it or sought a second opinion, and then the damage complained of would not have eventuated. The causal nexus alleged between the negligent act (the failure to disclose a material risk) and the damage complained of is therefore somewhat attenuated.

The requirement to consider “if only” draws attention, as it does in classical literary tragedy, to the possible ways in which catastrophe could have been averted. The difficulty comes in finding out what indicia of proof exist to confirm the subjective component of the standard – the material risks of concern to that particular patient.

The Australian High Court’s journey into the disjointed world of informed consent or alleged failure to disclose material medical risk began in the case of *Rogers v Whitaker* (1992) 175 CLR 479. It was a case redolent with tragedy (as we shall now examine) that may have (through the denial of justice) now contributed to a tragic area of jurisprudence.

The reported facts of *Rogers v Whitaker* provide a poignant counterpoint to those of *Wallace v Kam*. At the age of nine, the girl who subsequently married to become Mrs Whitaker suffered an accidental, penetrating wound to her right eye from a pointed stick from a banana packing case. When she was 10, a cataract was removed from the same eye and it was left without sight, except, with powerful symbolism as it subsequently eventuated, for the capacity to discern light from dark.

Mrs Whitaker worked in a variety of occupations, including shop assistant, enrolled nurses’ aide and health studio manageress. After ceasing employment to look after a son who had suffered brain damage in a car accident, she determined to re-enter the workforce. Her general practitioner, the poignantly named Dr Pentecost, told her that God had “spared her other eye for a reason”. But upon her insistence, he referred her to Dr Rogers, a “corneal graft expert”. The first consultation was long. Dr Rogers established that five things were wrong with the right eye: increased pressure, a cataract, a scar embedded both in and out of the iris, and a squint.

“You are lucky,” Dr Rogers said, according to Mrs Whitaker’s version of their conversation, “not that you have got five things wrong with the right eye, but that I specialise in the five problems.”

“It still seems like a miracle after all these years.”

“Mrs Whitaker this is a piece of cake these days otherwise I would not go ahead with the surgery. I promise you – look, you have nothing to worry about.”

“What if something goes wrong, I have only got one eye?”

“What makes you think anything can go wrong?”

“Well when I was speaking to Dr Pentecost ten years ago he said God had spared my left eye for a very good reason. If anything was to go wrong in his opinion it would have happened long before this, but poking away at your right eye at this late stage of the game, all sorts of things could go wrong. It would be like poking away at a hornet’s nest.”

As she recalled events, Mrs Whitaker repeated her concerns on a later occasion:

“Oh well”, said Dr Rogers, “Mrs Whitaker, we have already covered that territory. Your constantly asking me questions is like constantly asking a tradesman if he knows the tools of his trade. I can personally guarantee you that I would not go ahead with the surgery, Mrs Whitaker, if there was the slightest possibility, even the remotest thing, that you have to worry about. I can see how worried you are. I am not that sort of doctor.”

The tragic error was that the patient, despite what the High Court termed (at 487) her “incessant” questioning and “keen interest” in the outcome, was not informed of the risk of sympathetic ophthalmia, a rare condition in which a trauma to one eye causes a perilous infection in the other.

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5. See also *Whitaker v Rogers* (1990) Aust Torts Reports 81-062 (Campbell J).


Mrs Whitaker was taken into the theatre having drawn an arrow over the bandage on her good eye directing surgical attention to the other eye. After the operation, Mrs Whitaker saw Dr Rogers a few times in his rooms, complaining of blurred vision in her left eye. He found a dilated pupil and prescribed antibiotic drops. One night she experienced excruciating pain and rang the doctor’s office next morning. He didn’t see her until the following day. After that consultation, Mrs Whitaker was placed in hospital and diagnosed with sympathetic ophthalmia. She eventually underwent three operations but to no avail; she lost the sight of her left eye. Combined with the state of her right eye, she was effectively blind.

Mrs Whitaker’s story is an archetypal case for patients alleging medical failure to disclose material risk. Like all such instances, it presents in an extremely stark fashion a tragic contrast between hope and trust. Mrs Whitaker struggled through life with one good eye; she hoped surgery would restore her to two; but she was left with none. The contrast between hope and failure is highlighted not only by the failure of the operation to improve her “bad eye” but because in the process her “good eye”, which the fates had spared, was irreparably damaged. Long familiar, we may presume, to life with only one eye, her hopes for normality were raised by Dr Rogers. For 40 years she had learned to cope and to succeed by performance of a socially useful role. Dr Rogers had also developed a virtuous life narrative through community service. He genuinely wished to help Mrs Whitaker and performed the operation upon her with due technical skill and proficiency. The consequences of the rare complication of sympathetic ophthalmia must have been, therefore, a particularly devastating tragedy for both patient and doctor.

**Wallace v Kam and the medical duty to disclose material risk prior to an operation**

Having reprised the archetypal circumstances of Rogers v Whitaker, we are now in a better position to consider the hypothesis whether tragic circumstances assist in instructively characterising the case of Wallace v Kam (2013) 87 ALJR 648; [2013] HCA 19. The joint judgment of the Australian High Court focused primarily on the issue of causation of damage (at [9]-[10]):

However, consistent with the underlying purpose of the imposition of the duty to warn, the damage suffered by the patient that the common law makes compensable is not impairment of the patient’s right to choose. Nor is the compensable damage exposure of the patient to an undisclosed risk. The compensable damage is, rather, limited to the occurrence and consequences of physical injury sustained by the patient as a result of the medical treatment that is carried out following the making by the patient of a choice to undergo the treatment.\[^8\]

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 to exercise reasonable care and skill to warn the patient of one or more material risks inherent in that treatment.

The High Court found that the issue of causation in the common law of negligence requires determination of both a question of historical fact as to how particular harm occurred, and a normative question as to whether legal responsibility for that particular harm occurring in that way should be attributed to a particular person.\[^9\] It found confirmation of this view in s 5D of the Civil Liability Act 2002 (NSW), which is substantially replicated in each other Australian State and the Australian Capital Territory.\[^10\] It provides:

1. A determination that negligence caused particular harm comprises the following elements:
   a. that the negligence was a necessary condition of the occurrence of the harm (factual causation), and

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\[^10\] Wrongs Act 1958 (Vic), s 51; Civil Liability Act 1936 (SA), s 34(1), (3); Civil Liability Act 2003 (Qld), s 11; Civil Liability Act 2002 (WA), s 5C. Civil Liabilities Act 2002 (Tas), s 13; Civil Law (Wrongs) Act 2002 (ACT), s 45(1), (3).
(b) that it is appropriate for the scope of the negligent person’s liability to extend to the harm so caused (scope of liability).

(2) 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.

(3) If it is relevant to the determination of factual causation to determine what the person who suffered harm would have done if the negligent person had not been negligent:
   (a) the matter is to be determined subjectively in the light of all relevant circumstances, subject to paragraph (b), and
   (b) any statement made by the person after suffering the harm about what he or she would have done is inadmissible except to the extent (if any) that the statement is against his or her interest.

(4) For the purpose of determining the scope of liability, 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.

The High Court found (at [13]) that s 5E of the Civil Liability Act, which is also substantially replicated in each other Australian State and the Australian Capital Territory, provides that, in determining liability for negligence, “the plaintiff always bears the onus of proving, on the balance of probabilities, any fact relevant to the issue of causation”.

The High Court made it clear (at [14]) that it saw no value in “judicial glosses” obscuring the distinction now drawn by s 5D(1) between factual causation on the balance of probabilities (and the “but for” test of causation) and the normative issue of scope of liability (s 5D(1)(b)). The High Court pointed out that, in a case where the basis of the patient’s cause of action is that her or his doctor failed to warn them of a material risk, the legislation requires that the matter be determined subjectively (that is, according to the particular concerns of the patient) except that statements made by the patient after the harm are inadmissible unless they are against interest (s 5D(3)(b)). The High Court found Rosenberg v Percival (2001) 205 CLR 434 to be a case where the patient would have chosen to undergo the treatment even if warned of all material risks. It found Rogers v Whitaker (1992) 175 CLR 479 to be a situation where the patient would have chosen not to undergo the treatment at all if warned of all material risks. It found Chappel v Hart (1998) 195 CLR 232 to illustrate a third scenario where the patient, if warned of material risks, would have chosen to undergo the treatment but by someone else at a later time. The High Court considered this to be “a scenario in which a determination of factual causation should be made” (at [20]).

As regards the normative component of liability (s 5D(3)(b)), “[t]he common law method is that a policy choice once made is maintained unless confronted and overruled” (at [22]). The High Court found (at [23]) that s 5D(4) requires “the identification and articulation of an evaluative judgment by reference to ‘the purposes and policy of the relevant part of the law’”. Language of “directness”, “reality”, “effectiveness” or “proximity” will rarely be adequate to that task. “Resort to ‘common sense’ will ordinarily be of limited utility unless the perceptions or experience informing the sense that is common can be unpacked and explained” (at [23]). It held (at [24]) that “liability for breach of a duty to exercise reasonable care and skill to avoid foreseeable harm does not extend beyond harm that

11 Wrongs Act 1958 (Vic), s 52; Civil Liability Act 1936 (SA), s 35; Civil Liability Act 2003 (Qld), s 12; Civil Liability Act 2002 (WA), s 5D; Civil Liability Act 2002 (Tas), s 14; Civil Law (Wrongs) Act 2002 (ACT), s 46.
12 Strong v Woolworths Ltd (2012) 246 CLR 182 at [18].
13 See also Chester v Afshar (2005) 1 AC 134.
was foreseeable at the time of breach”.  

The court gave the example (at [24]) of a mountaineer who is negligently advised by a doctor that his knee is fit to make a difficult climb and who then makes the climb, which he would not have made if properly advised about his knee, only to be injured in an avalanche. His injury is a “foreseeable consequence of mountaineering but has nothing to do with his knee”.

It held (at [25]) that a “medical practitioner is not liable to a patient for physical injury that represents the materialisation of a risk about which it is beyond the duty of the medical practitioner to warn”.

Applied to the instant case, the High Court found that Dr Kam breached his single comprehensive duty to exercise reasonable care and skill in the provision of professional advice and treatment to Mr Wallace by failing to warn Mr Wallace of two material risks of physical injury inherent in the surgical procedure Dr Kam was to perform: the risk of neurapraxia and the risk of paralysis. If warned of all material risks, Mr Wallace would have chosen not to undergo the surgical procedure at all and would therefore not have sustained the neurapraxia. Section 5D(1)(a) is satisfied. Section 5D(2) is irrelevant. Yet, on s 5D(1)(b) the High Court held (at [34]-[36]) that while [t]o fail to warn the patient of one factor while informing the patient of another may in a particular case be to fail to warn the patient of the extent of the risk and thereby to expose the patient to a level of risk of the physical injury occurring that is unacceptable to the patient, [such reasoning] is not directed or applicable to a case such as the present where what is involved is the materialisation of one of a number of distinct risks of different physical injuries. To fail to warn the patient of one risk while informing the patient of another may still in such a case be to expose the patient to a level of risk of physical injury occurring that is unacceptable to the patient. But the risk of physical injury that comes home in such a case is not necessarily the risk of physical injury that is unacceptable to the patient.

... The underlying policy is rather to protect the patient from the occurrence of physical injury the risk of which is unacceptable to the patient.

The High Court held (at [38]) that “essentially the same rule of attribution, and the same justification for that rule”, were articulated in the seminal United States case of *Canterbury v Spence* 464 F 2d 772 (1972). The High Court dismissed the appeal with costs on the basis that Dr Kam was not liable to Mr Wallace for impairment of Mr Wallace’s right to choose whether or not to undergo the surgical procedure and not liable to Mr Wallace for exposing him to an unacceptable risk of catastrophic paralysis. He could be liable, if at all, for the neurapraxia Mr Wallace sustained. As both Allsop P and Basten JA pointed out, the position of Mr Wallace in respect of the neurapraxia when considered for the purposes of causation is in principle no different from what his position would have been had Dr Kam properly warned him of the risk of neurapraxia and had he made an express choice to proceed with the surgical procedure in light of that warning. He is not to be compensated for the occurrence of physical injury the risk of which he was prepared to accept.

None of this, though obviously distressing to both doctor and patient, seems particularly tragic until we consider what such a precedent may mean for subsequent instances where patients suffer injury they never expected to encounter as a result of an operation.

**DISCLOSURE OF MATERIAL RISK AS A SYSTEMS-ERROR TRAGEDY**

The High Court justices in *Wallace v Kam* (2013) 87 ALJR 648; [2013] HCA 19 should not be overly faulted for attempting to tie together a stream of authority in a way that is logical, yet one is left with


the overwhelming feeling that it is part of an unjust and inequitable outcome for patients. To discover why this may be so, we now turn to perhaps an unusual point of comparison or source of insight: classical literary tragedy.

Even from ancient times there has been far from unanimous agreement that literary tragedy performed a useful social function. Plato in *The Republic* criticised literary tragedy as failing to attempt to present the truth about human relations and as merely stimulating destructive emotions that a good person should strive to control. Aristotle’s response in *The Poetics* was that tragedy presents us with sympathetic people who, like health professionals, have previously developed conspicuous, though not preeminent, virtue and esteem through performance of a socially useful role. In the space of what is usually a single dramatic action, precipitated by ignorance, pitiable reversals or recognitions, they suffer sympathetically identifiable, and at least partially undeserved, destruction of that fortune and good character by a fate that is blind to considerations of individual justice. The stated artistic purpose is to achieve a worthwhile catharsis that profoundly instructs and rouses conscience. In this latter process, Aristotle’s *Poetics* may be conceived of as a means of popular instruction in his *Nicomachean Ethics*.

Wilson Knight noted how classical literary tragedy uses various artistic techniques to arouse conscience in audience response to stories of human suffering heightened by human imperfection. This connection is particularly poignant for clinical medicine where health professionals have taken an oath to serve the relief of suffering in patients by expressing the highest virtues. The dramatic contrast between an expectation of loyalty or trust, and downfall, disappointment or betrayal is frequently central to classical literary tragedy, just as it is in the development and application of medico-legal jurisprudence in cases such as those involving disclosure of material risk.

It is through literary devices emphasising choice and fated constraint, such as reversal and discovery, that the genre of classical literary tragedy addresses the experience of suffering arising from loss of human control. It may do so in two distinct ways. First, it may draw our attention to a "tragic flaw" fatefully nestled deep within the protagonist’s psyche at a level far below their ability to rationally control it: the young lovers’ impetuousness, Dr Faustus’ hubris, Hamlet’s indecision, King Lear’s pride, the Moor’s passion, Macbeth’s ambition, all bring about their ruin. Likewise in medico-legal cases, the very courage and confidence which may allow a skilful doctor to hazard a risky operation to save a patient may also lead her or him to consider it unnecessary to furnish a patient with all the gruesome details of possible material risks.

Secondly, however, and more importantly for normative development in areas of medical negligence such as disclosure of material risk, classical literary tragedy may accentuate focus on the inexorable forces of fate and power which limit the protagonist’s scope to avoid the harm. Bradley thus writes:

What, then, is this “fate” … the ultimate power in the tragic world? It appears to be a mythological expression for the whole system or order, of which the individual characters form an inconsiderable and feeble part; which seems to determine, far more than they, their native dispositions and their circumstances, and, through these, their action; which is so vast and complex that they can scarcely at all understand it or control its workings.

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Fate’s blindness to considerations of individual “justice” in the Shakespearean tragedies was a ground of complaint on the part of that notorious bardolator, Dr Johnson. The facts of classical literary tragedy are not designed, Bradley countered, to definitively answer “ideas of justice and desert”. Costas Douzinas, writing on Antigone, Sophocles’ masterpiece of tragic quasi-jurisprudence, discusses the usefulness of the play in arousing a wide range of conflicting emotions and principles concerning the foundational social virtue of justice.

Modern directors of Shakespeare’s tragedies have sought to make this point explicit. For example, Imre Csiszar set Macbeth on a dunghill and King Lear in a decaying factory. In Ingmar Bergman’s 1984 Stockholm production of Lear, a writhing line of “naked wretches” on the heath became the storm itself. Robert Sturua’s 1987 Lear in Tbilisi ended with a simulated nuclear explosion. Strehler based the set for his 1972 Lear on TS Eliot’s Wasteland. In 1954 Nikolai Okhlopkov presented Hamlet on an “iron curtain” stage. Peter Brooks, following Jan Kott, interpreted fate in the Shakespearean tragedies as the absurdities and capriciousness of justice in a police state; Lear’s meeting with the blind Gloucester at Dover becoming reminiscent of Brecht’s Endgame. Hence one assumes it will only be a question of time till Macbeth is set in Dealey Plaza, Dallas, 22 November 1963, and the sequel Hamlet in the last days of Bobby Kennedy during the Presidency of LBJ; the Tempest on an international space station after a global climate change catastrophe; Romeo and Juliet to the backdrop of the feud between Israelis and Palestinians; and King Lear amidst the shattering empire of News Ltd and Fox News.

The tragic form assists humans to realise that it is through nuances of unanticipated adverse circumstance that even those striving to be good may lose control of their lives. In this context, doctors and patients alike thus, should they wish to embrace wisdom, must reflect upon the limited ability of their individual wills to impose upon and defeat the forces of disease, accident and incompetence ranged against them. Accepting vulnerability to such forces can create a sense of liberation, as happened with Tolstoy’s dying magistrate, Ivan Illych. Perhaps this was also what Nietzsche had in mind in considering literary tragedy a safe means of exploring the Dionysian part of our lives.

The relationship of ignorance to powerlessness, particularly through mistake or accident, is often central to classical literary tragedy, as it is in relations between health professional and patient. In Romeo and Juliet, eg, the two young lovers kill themselves because they do not have possession of all the facts: the letter from Friar Lawrence which explains to Romeo that Juliet is drugged, never reaches him. Seeing Juliet lying asleep in the tomb of the Capulets, he thinks she is dead and in grief kills himself. Thus the tragedy of Romeo and Juliet hinges on the young lovers’ impetuous ignorance of each other’s plans; King Lear on the King’s hubristic misunderstanding of the purport of Cordelia’s words; Othello on the Moor’s passionate mistake as to the significance of a handkerchief. How poignant must this analogy be to many patients who go ahead with an operation by a surgeon they trust and admire, without knowing all the material risks.

In specific terms, it is not surprising that a loss of vision (like that of Mrs Whitaker) with all its connotations of dependence and ignorance, features so prominently as the culmination of literary tragedy. Oedipus Rex is perhaps the most well-known such example. King Lear is another, drawing a

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27 Bradley, n 26, p 21.
28 Bradley, n 26, p 23.
35 Shakespeare W, Romeo and Juliet, Act V, Scene III, lines 90-120.
parallel between Lear’s moral blindness and Gloucester’s physical suffering. Each is condemned to wander in a raging storm which becomes a symbol of the fate oppressing them. Blindness may be a powerful metaphor for the type of absence of control and alienation experienced by many patients in the “stranger medicine” of a modern, technologically-based health system dominated by the profit-making machinations of health management corporations and multinational pharmaceutical cartels.

It is understandable, given the pervasive fear of litigation, that doctors, rather than encouraging any kind of exploration of the events which have given rise to the tragedy, instead close off and retreat behind a sullen veil of secrecy. The current system of tortious compensation requiring threatened or actual legal proceedings in many jurisdictions shows little formal appreciation of the increasing evidence for the role of system error in such cases.

Yet, perhaps the most important reason for continuing the analogy between disclosure of material risk cases and classical literary tragedy relates to the enhanced capacity that knowledge of classical literary tragedy may bring to encouraging readers to view medical negligence cases in terms of systems error. In other areas of human endeavour, the notion was dispensed with long ago that safety could be ensured primarily by examining deficiencies in the performance of individuals rather than defects in the system. Efforts have been made to introduce this notion, in the guise of continuous quality improvement and adverse incident monitoring systems, into the health care system, but the effort has yet to permeate medico-legal jurisprudence in any systematic way. An outcome of this lack of personal engagement with system error in medico-legal jurisprudence may be the growth of practices of defensive medicine, or the emergence of informed consent forms as a sheath of protection against, rather than a tool in aid of, doctor-patient communication. Let us now examine how the medical negligence system may have become tragically unjust in this area.

TRAGIC SYSTEMS CONTEXT ON DISCLOSURE OF MATERIAL RISK

The legislation and case law on disclosure of material risk must always be calibrated against the norms of bioethics and international human rights (ie, free consent before medical treatment or research as found in Art 7 of the International Covenant on Civil and Political Rights (ICCPR) and s 10(2) of the Human Rights Act 2004 (ACT)). In Australia, eg, the National Health and Medical Research Council’s Guidelines on Communication to Patients are just as important in framing a health professional’s duty as the World Medical Association’s modern statement of the Hippocratic Oath (Geneva Declaration) and the Australian Medical Association’s Code of Ethics. This is because, ever since the Nuremberg Declaration following the Nazi doctors’ trial, it is no excuse for a doctor who harms a patient to plead, “I was only following the law”. This code of radical civil disobedience at the heart of medical professionalism is reinforced in Australia by a broad constitutional guarantee in s 51(xxiiiA) prohibiting federal laws purporting to require medical services to be performed under the control of the state or private corporations, so that they practically involve “any form of civil conscription”. This constitutional protection encompasses the tradition of conscientious objection to conscription that has proven such a powerful proving ground for the strength of individual moral beliefs.

36 Shakespeare W, King Lear, Act III, Scene VII, lines 82-83.
41 Wong v Commonwealth; Selim v Professional Services Review Committee (2009) 236 CLR 573.
Yet the tragedy for patients and their relatives involved in disclosure of material risk cases has been compounded by a raft of recent legislation in Australian States that has resulted in fewer claims and more profits for medical indemnity insurers, but not fewer patients being injured as a result of adverse events.

In the early 2000s a committee of four experts headed by Justice David Ipp received terms of reference requiring them to examine the law of negligence with the objective of limiting liability and quantum of damages arising from personal injury and death. The Ipp Committee was told that it must assume that it was “desirable” to limit the responsibility of people who behaved recklessly and limit the amounts that their insurers should pay to those harmed by their careless conduct. It was prevented from examining the true nature of the insurance market and the factors responsible for the insurance “crisis”.42

As a direct result of recommendations from the Ipp Committee, statutes restricting the rights of citizens to bring civil liability claims were introduced by Australian State legislatures.43 Some viewed these legislative changes as intended to “restore an appropriate balance between personal responsibility for one’s own conduct and expectations of proper compensation and care”.44 A major factor encouraging these massive restrictions on the capacity of injured patients to receive fair compensation was the threatened bankruptcy of the largest medical indemnity defence organisation in Australia, United Medical Protection (UMP), and of one of the largest public liability and professional indemnity insurers in Australia, HIH, allegedly due to rising costs as a result of a number of large payouts.45 An actuarial report to a joint meeting of government ministers from the Commonwealth and the States attributed this alleged rise in insurance company expenditure to increased costs of claims.46 It remains questionable whether there was, in fact, any increase in the volume of civil liability litigation or related size of verdicts in Australia in this period. It appears equally likely that the insurance liquidity problems were due to poor management decisions in the industry.47

Chief Justice of Queensland, Paul de Jersey, has stated that these legislative changes “brought about marked erosion of a fundamental human right to personal safety and security and to receive adequate compensation” for injury caused by negligence. In an extra-curial speech he said the critical issue now was “the need for active reconsideration of whether the so-called reforms have proven justified, or should be wound back”. He stated that particularly unjust statutory changes to Queensland tort laws included caps on damages, restrictions on compensation to family and friends for free care given to injured people and limits on legal fees refundable for smaller claims.48 That these harsh rules had to be changed specifically to permit compensation for the Bundaberg Hospital victims of negligent surgery, arguably only highlights their injustice to other injured patients in that State.49 Some of this legislation, eg in Queensland, has abolished the second (subjective) half of the Rogers v Whitaker test in order to reduce the number of tortious claims being made against doctors which were provoking a

43 civil law wrongs act 2002 (act); civil liability act 2002 (nsw); civil liability act 2002 (wa); civil liability act 2002 (tas); personal injuries (liability and damages) act 2003 (nt); and by amendments to the wrongs act 1958 (vic) and the wrongs act 1936 (sa). see also trade practices amendment (personal injury and death) act (no 2) 2004 (cth).
47 wright t and melville a, “hey, but who’s counting: the metrics and politics of trends in civil litigation” in prest w and roach anleu sl (eds), litigation: past and present (university of new south wales press, sydney, 2003) p 96.
49 australian lawyers alliance, n 48.
medical indemnity crisis. Legislation also included in some jurisdictions the capacity for doctors to say they are sorry without incurring liability, penalties for failing to settle early or having a case that does not reach a threshold of seriousness.

In Victoria, Judge Tom Wodak, who managed the medical civil litigation list for a lengthy period after its inception in 1998, claimed that the medical negligence litigation “crisis” supposedly driving such changes was a “myth” that had been generated by powerful lobbying from the insurance industry and the medical profession. He stated:

In Victoria, in my opinion, there was no crisis in medical negligence litigation, so far as this can be gauged from the medical list in the County Court. I do not consider that the relatively stable pattern of commencement of proceedings from year to year, until 2003, discloses any burgeoning of claims numerically, or quantitatively.

Judge Wodak pointed out there was a very high rate of settlement of County Court medical proceedings, fewer than 50 new medical claims in the Supreme Court each year and that he knew of no enormous damages payouts in Victoria.50

In other States, these statutory changes put limitations on medical negligence actions in the form of restrictions on the duty of care owed by public authorities, the exclusion of an action for damages in wrongful birth actions for the cost of child rearing, caps on damages for personal injury and an inability on the part of plaintiffs to give evidence to establish causation in failure to warn cases, as well as the introduction of a modified Bolam principle (which allowed doctors to avoid liability by bringing evidence that even a few, although not necessarily the majority of, reasonably competent practitioners would have done what they did).51 There is a particularly great potential injustice, in this context, of the Federal Government also subsidising the professional indemnity costs of doctors. One consequence, eg, is that a taxpaying patient injured through the negligence of a doctor (on standard common law criteria) would not only be prevented from suing to receive reasonable compensation but would be forced to subsidise that physician’s indemnity insurance.

Given that key judges in multiple jurisdictions have spoken out against the changes, a specific hypothesis may be proposed. This is that, in cases interpreting such legislation, judges, in the best traditions of the common law and equity, may exhibit a willingness in appropriate cases to modify the statutory scheme in order to remedy any perceived injustices in its operation.

Justice David Ipp, a chief architect of the reforms, himself has since confirmed a widespread opinion among the judiciary, academics, the public and policy-makers that the legislative changes have gone too far. He has stated:

Judges at the highest level have expressed unease. The legal profession and victims’ associations are unhappy and are clamouring for change. They are conducting a well-orchestrated campaign for reform. This brings about an atmosphere of uncertainty and instability... There is a clear clash of values and interests between the different participants in the politics of negligence.52

How the civil liability legislative changes treat disabled children and the mentally ill are two particular focal points for claims of injustice. One effect of the recommendations of the Ipp Committee, eg, was that the interests of certain classes of disabled children were subrogated to those of industry and business groups which successfully lobbied legislators that they would only achieve affordable insurance if the legal rights of such children were removed.53 The Ipp Committee’s report (and the legislative changes arising from it) allegedly also exhibited discrimination against Australians with mental illness who were denied compensation in many cases simply because of their medical

52 Ipp, n 42.
condition. Such claims of injustice mirror those involving health insurance companies in the United States which led to recent legislation prohibiting them from excluding claimants (including children) because of pre-existing conditions.

A particular claim of potential injustice is that the Ipp Report failed to address the omissions of the Australian Prudential Regulation Authority (APRA) whose duty was to scrutinise and investigate the management and operation of the relevant insurers. Indeed, it has been argued that the terms of reference for the Ipp review and the make-up of the panel were straight from the insurers’ “wish list” and that insurance companies conducted a very successful public relations campaign and deliberately created hysteria among the public to panic legislators into making laws that suit them.

All of this leads to the conclusion that the Australian High Court in its most recent decision on disclosure of material risk, by showing undue deference to a fundamentally unjust stream of legislative change, may once again be providing evidence that it is incrementally abdicating its constitutional role to provide a check and balance on the potential despotism over Australian citizens of elected cliques and those interests capable of unduly influencing them. Perhaps the justification for this judicial deference is that Parliament is viewed by some judges as in every circumstance legitimately representing, through the democratic process, the free will of its citizens. If so, this fails to appreciate or confront (in the interests of justice, equity and environmental sustainability) the extent to which the contemporary state has been captured in its primary functions by economically powerful corporations.

**CONCLUSION**

The hypothesis explored here, through analysis of *Wallace v Kam* in its legislative context, is that an understanding of the traditional elements of classical literary tragedy helps key stakeholders approach medico-legal cases on disclosure of material risk in a manner more conducive to understanding an increasingly important regulatory truth. This truth is that fault in these cases lies most often with what may be termed an overarching system (Lear’s “wheel of fire,” or Hamlet’s rank and rotten state) and not the individual professionals working within it. In medicine it is the overarching system that is characterised increasingly by private insurance companies subsidised by the taxpayers whose capacity to claim they restrict, by rights-restricting legislation passed as a result of successful lobbying by private interest groups, by multinational companies shaping the regulatory architecture on access to medicine and medical services. The Australian High Court seems insensitive to this context of its health system-related decisions and, if this trend continues, it will, indeed, become a tragic institution.

If such an analysis is but partially correct, then we are right to hold up the fierce determination of Mrs Whitaker (that “everywoman” of patient informed consent) to right the injustice served upon her by our legal system. Having fought the legal system for compensation through three courts, she then fought the most omnipresent symbol of bureaucratic fate: the taxation office. She had been awarded $808,564.38 plus $65,514.38 pre-judgment interest and $287,671 post-judgment interest. The Federal Commissioner of Taxation wished to tax the interest as ordinary income. She failed in the Federal Court at first instance and on appeal in respect of the post-judgment interest. Undeterred, Mrs Whitaker launched a letter-writing campaign which eventually pestered the Minister for Taxation to introduce tax law amendments. These exempted from tax post-judgment interest on awards for damages in personal injury compensation cases. The amendments were retrospective to the income year (1992-1993) of the High Court decision in *Rogers v Whitaker*. It is time for the legal profession to show the same determination on behalf of medically injured patients. To say that Mr Wallace in the

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instant case must be less worthy in our eyes because his opportunities for virtue were diminished through having had less to fight for is surely an exercise in reason no less likely to be tragic if taken to its logical conclusion.

Reading medico-legal cases from the tragic perspective encourages regulators (both legislative and judicial) to realise that many technocratic, bureaucratic, corporate and scientific processes of modern medicine may militate against patient consent ever being truly informed about the objective and subjective material risks of planned operations. It is true that small changes can be made to assist patients get greater justice from the system: consent forms could be standardised across the nation to allow space for patients to write their individual concerns and acknowledge they have been answered. Such forms could also be consistently amended to allow full disclosure of financial conflicts of interest.

Yet the final ironic truth may be that the structures of the modern medico-legal system are so obsessed with the pursuit of individual blame and the increasingly dominant private corporate architecture so focused on risk and liability minimisation and profit maximisation, that those working within it (including the Australian High Court) continue to suffer a systemic blindness or even sense of hopelessness concerning their ability to change them to better reflect a genuine commitment to upholding, in the face of obstacles, foundational professional virtues and their supporting universal principles. At some fundamental level, it is unlikely that such a situation will long be tolerated.

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