ROGERS V WHITAKER (1992) HCA

MASON CJ, BRENNAN, DAWSON, TOOHEY, AND MCHUGH JJ

Breach of duty
5. Neither before the Court of Appeal nor before this Court was there any dispute as to the **existence of a duty of care** on the part of the appellant to the respondent**. 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" ((2) Sidaway v. Governors of Bethlem Royal Hospital (1985) AC 871, per Lord Diplock at p 893); **it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case** ((3) Gover v. South Australia (1985) 39 SASR 543, at p 551.). It is of course necessary to give content to the duty in the given case.

8. The Bolam principle has invariably been applied in English courts ((7) Whitehouse v. Jordan; Maynard v. West Midlands R.H.A; Hills v. Potter (1984) 1 WLR 641; Sidaway; Blyth v. Bloomsbury Health Authority, unreported, Court of Appeal, 5 February 1987; Gold v. Haringey Health Authority (1987) 3 WLR 649.). In decisions outside the field of medical negligence, there are also statements consistent with an application of the Bolam principle ((8) Mutual Life Ltd. v. Evatt (1971) AC 793, at p 804; Saif Ali v. Sydney Mitchell and Co. (1980) AC 198, at pp 218, 220.). **At its basis lies the recognition that, in matters involving medical expertise, there is ample scope for genuine difference of opinion and that a practitioner is not negligent merely because his or her conclusion or procedure differs from that of other practitioners** ((9) See Hunter v. Hanley (1955) SLT 213, per Lord President Clyde at p 217); a finding of negligence requires a finding that the defendant failed to exercise the ordinary skill of a doctor practising in the relevant field. Thus, in Whitehouse v. Jordan ((10) (1981) 1 WLR 246), judgment entered for the plaintiff was set aside because, in the face of expert evidence that the defendant's efforts in delivering the plaintiff were competent, there was insufficient evidence upon which the trial judge could hold that there was negligence. Similarly, in Maynard v. West Midlands R.H.A ((11) (1984) 1 WLR 634), judgment entered for the plaintiff was set aside on the ground that it was not sufficient to establish negligence on the part of the defendant to show that there was a body of competent professional opinion that considered the decision to perform a particular operation was wrong when there was also a body of equally competent professional opinion which supported that decision as reasonable.

10. In dissent, Lord Scarman refused to apply the Bolam principle to cases involving the provision of advice or information. His Lordship stated ((17) (1985) AC, at p 876.):
"In my view the question whether or not the omission to warn constitutes a breach of the doctor's duty of care towards his patient is to be determined not exclusively by reference to the current state of responsible and competent professional opinion and practice at the time, though both are, of course, relevant considerations, **but by the court's view as to whether the doctor in advising his patient gave the consideration which the law requires him to give to the right of the patient to make up her own mind in the light of the relevant information whether or not she will accept the treatment which he proposes.**"

His Lordship referred to American authorities, such as the decision of the United States Court of Appeals, District of Columbia Circuit, in Canterbury v. Spence ((18) (1972) 464 F 2d 772), and to the decision of the Supreme Court of Canada in Reibl v. Hughes ((19) (1980) 114 DLR (3d) 1), **which held 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.**

11. One consequence of the application of the Bolam principle to cases involving the provision of advice or information is that, even if a patient asks a direct question about the possible risks or complications, the making of that inquiry would logically be of little or no significance; medical opinion determines whether the risk should or should not be disclosed and the express desire of a particular patient for information or advice does not alter that opinion or the legal significance of that opinion. The fact that the various majority opinions in Sidaway ((20) (1985) AC, at pp 895, 898, 902-903), for example, suggest that, over and above the opinion of a respectable body of medical practitioners, **the questions of a patient should truthfully be answered** (subject to the therapeutic privilege) indicates a shortcoming in the Bolam approach. The existence of the shortcoming suggests that an acceptable approach in point of principle **should recognize and attach significance to the relevance of a patient's questions.** Even if a court were satisfied that a reasonable person in the patient's position would be unlikely to attach significance to a particular risk, **the fact that the patient asked questions revealing concern about the risk would make the doctor aware that this patient did in fact attach significance to the risk.** Subject to the therapeutic privilege, **the question would therefore require a truthful answer.**

12. In Australia, it has been accepted that the standard of care to be observed by a person with some special skill or competence is that of the ordinary skilled person exercising and professing to have that special skill ((21) Cook v. Cook (1986) 162 CLR 376, at pp 383-384; Papatonakis v. Australian Telecommunications Commission (1985) 156 CLR 7, at p 36; Weber v. Land Agents Board (1986) 40 SASR 312, at p 316; Lewis v. Tressider Andrews Associates Pty. Ltd. (1987) 2 Qd R 533, at p 542.). But, that standard is not determined solely or even primarily by reference to the practice followed or supported by a responsible body of opinion in the relevant profession or trade ((22) See, for example, Florida Hotels Pty. Ltd. v. Mayo (1965) 113 CLR 588, at pp 593, 601). **Even in the sphere of diagnosis and treatment, the heartland of the skilled medical practitioner, the Bolam principle has not always been applied** ((23) See Albrighton v. Royal Prince Alfred Hospital (1980) 2 NSWLR 542, at pp 562-563 (case of medical treatment). See also E v. Australian Red Cross (1991) 99 ALR 601, at p 650). **Further, and more importantly, particularly in the field of non-disclosure of risk and the provision of advice and information, the Bolam principle has been discarded** and, instead, **the courts** have adopted ((24) Albrighton v. Royal Prince Alfred Hospital (1980) 2 NSWLR, at pp 562-563; F v. R. (1983) 33 SASR 189, at pp 196, 200, 202, 205; Battersby v. Tottman (1985) 37 SASR, at pp 527, 534, 539-540; E v. Australian Red Cross (1991) 99 ALR, at pp 648-650) **the principle that, while evidence of acceptable medical practice is a useful guide for the courts, it is for the courts to adjudicate on** what is the appropriate standard of care after giving weight to **"the paramount consideration that a person is entitled to make his own decisions about his life"** ((25) F v. R. (1983) 33 SASR, at p 193).

13. In F v. R. ((26) (1983) 33 SASR 189), which was decided by the Full Court of the Supreme

Court of South Australia two years before Sidaway in the House of Lords, a woman who had become pregnant after an unsuccessful tubal ligation brought an action in negligence alleging **failure by the medical practitioner to warn her of the failure rate of the procedure.** The failure rate was assessed at less than 1 per cent for that particular form of sterilization. The Court refused to apply the Bolam principle. King C.J. said ((27) ibid., at p 194):

"**The ultimate question, however, is not whether the defendant's conduct accords with the practices of his profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for the court and the duty of deciding it cannot be delegated to any profession or group in the community.**"

King C.J. considered ((28) ibid., at pp 192-193) that the amount of information or advice which a careful and responsible doctor would disclose depended upon a complex of factors: the nature of the matter to be disclosed; the nature of the treatment; **the desire of the patient for information;** the temperament and health of the patient; and the general surrounding circumstances. His Honour agreed with ((29) ibid., at pp 193-194) the following passage from the judgment of the **Supreme Court of Canada in Reibl v. Hughes** ((30) (1980) 114 DLR (3d), at p 13):

"To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. It will also have a bearing on their materiality but this is not a question that is to be concluded on the basis of the expert medical evidence alone. **The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment.**"

The approach adopted by King C.J. is similar to that subsequently taken by Lord Scarman in Sidaway and has been followed in subsequent cases ((31) Battersby v. Tottman; Gover v. South Australia (1985) 39 SASR, at pp 551-552; Ellis v. Wallsend District Hospital, unreported, Supreme Court of New South Wales, 16 September 1988; E v. Australian Red Cross (1991) 99 ALR, at pp 649-650). **In our view, it is correct.**

14. Acceptance of this approach does not entail an artificial division or itemization of specific, individual duties, carved out of the overall duty of care. The duty of a medical practitioner to exercise reasonable care and skill in the provision of professional advice and treatment is a **single comprehensive duty.** However, the factors according to which a court determines whether a medical practitioner is in breach of the requisite standard of care will vary according to whether it is a case involving diagnosis, treatment or **the provision of information or advice;** the different cases raise varying difficulties which require consideration of different factors ((32) F v. R. (1983) 33 SASR, at p 191). **Examination of the nature of a doctor-patient relationship compels this conclusion.** There is a fundamental difference between, on the one hand, diagnosis and treatment and, **on the other hand, the provision of advice or information to a patient.** In diagnosis and treatment, the patient's contribution is limited to the narration of symptoms and relevant history; the medical practitioner provides diagnosis and treatment according to his or her level of skill. However, except in cases of emergency or necessity, **all medical treatment is preceded by the patient's choice to undergo it.** In legal terms, the patient's consent to the treatment may be valid once he or she is informed in broad terms of the nature of the

procedure which is intended ((33) Chatterton v. Gerson (1981) QB 432, at p 443). But the choice is, in reality, meaningless unless it is made on the basis of relevant information and advice. Because the choice to be made calls for a decision by the patient on information known to the medical practitioner but not to the patient, it would be illogical to hold that the amount of information to be provided by the medical practitioner can be determined from the perspective of the practitioner alone or, for that matter, of the medical profession. Whether a medical practitioner carries out a particular form of treatment in accordance with the appropriate standard of care is a question in the resolution of which responsible professional opinion will have an influential, often a decisive, role to play; whether the patient has been given all the relevant information to choose between undergoing and not undergoing the treatment is a question of a different order. Generally speaking, it is not a question the answer to which depends upon medical standards or practices. Except in those cases where there is a particular danger that the provision of all relevant information will harm an unusually nervous, disturbed or volatile patient, no special medical skill is involved in disclosing the information, including the risks attending the proposed treatment ((34) See Fleming, The Law of Torts, 7th ed. (1987), p 110). Rather, the skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose having regard to the patient's apprehended capacity to understand that information.

15. In this context, nothing is to be gained by reiterating the expressions used in American authorities, such as "the patient's right of self-determination" ((35) See, for example, Canterbury v. Spence (1972) 464 F 2d, at p 784) or even the oft-used and somewhat amorphous phrase "informed consent". The right of self-determination is an expression which is, perhaps, suitable to cases where the issue is whether a person has agreed to the general surgical procedure or treatment, but is of little assistance in the balancing process that is involved in the determination of whether there has been a breach of the duty of disclosure. Likewise, the phrase "informed consent" is apt to mislead as it suggests a test of the validity of a patient's consent ((36) Reibl v. Hughes (1980) 114 DLR (3d), at p 11). Moreover, consent is relevant to actions framed in trespass, not in negligence. **Anglo-Australian law has rightly taken the view that an allegation that the risks inherent in a medical procedure have not been disclosed to the patient can only found an action in negligence and not in trespass**; 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 ((37) Chatterton v. Gerson (1981) QB, at p 443). In Reibl v. Hughes the Supreme Court of Canada was cautious in its use of the term "informed consent" ((38) (1980) 114 DLR (3d), at pp 8-11).

16. We agree that the factors referred to in F v. R. by King C.J. ((39) (1983) 33 SASR, at pp 192-193) **must all be considered by a medical practitioner in deciding whether to disclose or advise of some risk in a proposed procedure.** The law should recognize that a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; 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 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. This duty is subject to the therapeutic privilege.

18. The evidence established that there was a body of opinion in the medical profession at the time which considered that an inquiry should only have elicited a reply dealing with

sympathetic ophthalmia if specifically directed to the possibility of the left eye being affected by the operation on the right eye. While the opinion that the respondent should have been told of the dangers of sympathetic ophthalmia only if she had been sufficiently learned to ask the precise question seems curious, it is unnecessary for us to examine it further, save to say that it demonstrates vividly the dangers of applying the Bolam principle in the area of advice and information. The respondent may not have asked the right question, **yet she made clear her great concern that no injury should befall her one good eye.** The trial judge was not satisfied that, if the respondent had expressed no desire for information, proper practice required that the respondent be warned of the relevant risk. But it could be argued, within the terms of the relevant principle as we have stated it, **that the risk was material, in the sense that a reasonable person in the patient's position would be likely to attach significance to the risk, and thus required a warning.** It would be reasonable for a person with one good eye to be concerned about the possibility of injury to it from a procedure which was elective. **However, the respondent did not challenge on appeal that particular finding.**

Gaudron J

2.There is no difficulty in analysing the **duty of care of medical practitioners on the basis of a "single comprehensive duty"** ((40) Sidaway v. Governors of Bethlem Royal Hospital (1985) AC 871, per Lord Diplock at p 893) covering diagnosis, treatment and the provision of information and advice, provided that it is stated in terms of sufficient generality. Thus, the general duty may be stated as a duty to exercise reasonable professional skill and judgment. But the difficulty with that approach is that a statement of that kind says practically nothing - certainly, nothing worthwhile - as to the content of the duty. **And it fails to take account of the considerable conceptual and practical differences between diagnosis and treatment, on the one hand, and the provision of information and advice, on the other.**

4. The matters to which reference has been made indicate that the **evidence of medical practitioners is of very considerable significance in cases where negligence is alleged in diagnosis or treatment.** However, even in cases of that kind, the nature of particular risks and their foreseeability are not matters exclusively within the province of medical knowledge or expertise. Indeed, and notwithstanding that these questions arise in a medical context, **they are often matters of simple commonsense**. And, at least in some situations, questions as to the reasonableness of particular precautionary measures are also matters of commonsense. Accordingly, even in the area of diagnosis and treatment there is, in my view, no legal basis for limiting liability in terms of the rule known as "the Bolam test" ((42) This test derives from the charge to the jury by McNair J. in **Bolam v. Friern Hospital Management Committee** (1957) 1 WLR, at p 587) which is to the effect that a doctor is not guilty of negligence if he or she acts in accordance with a practice accepted as proper by a responsible body of doctors skilled in the relevant field of practice. That is not to deny that, having regard to the onus of proof, "the Bolam test" may be a convenient statement of the approach dictated by the state of the evidence in some cases. As such, it may have some utility as a rule-of-thumb in some jury cases, but it can serve no other useful function.

5. Diagnosis and treatment are but particular duties which arise in the doctor-patient relationship. That relationship also gives rise to a duty to provide information and advice. That duty takes its precise content, in terms of the nature and detail of the information to

be provided, from the needs, concerns and circumstances of the patient. A patient may have special needs or concerns which, if known to the doctor, will indicate that special or additional information is required. In a case of that kind, the information to be provided will depend on the individual patient concerned. In other cases, where, for example, no specific enquiry is made, the duty is to provide the information that would reasonably be required by a person in the position of the patient.

Doctors have a duty to warn their patients of material risks, a risk is material if a patient attaches significance to it, to provide information and advice , and even if no specific enquiry is made, there is still a duty on the doctor to provide the patient with potential risks.

Providing the patient with information and advice requires no particular medical skill, and reference to the standards of their peers , which is applicable in cases of negligence in diagnosis and treatment , the Bolam principle , are not applicable to the provision of advice and information.

The State and its regulatory authorities, such as AHPRA, by citing "board guidelines" as determinant if a practitioner has complied with their duty of care to the patient has no basis in law. There is no legal requirement to comply with any Board guidelines , nor does compliance offer a valid legal defence.

Furthermore, there is no legal obligation whatsoever on a practitioner to promote or endorse any health policy of the State, and equally, there is no obligation on the general public to comply with any health policy or Public health or well being act of the State- for example the Public Health and Wellbeing Act 2008 Vic, see sections 4-9.

On the contrary, if a practitioner does promote or endorse these "vaccines", without any long term data on efficacy or safety, they would most likely be found guilty of negligence should harm occur.

In Australia, the provision of medical services occurs pursuant to a private contract between doctor-patient, the doctor -patient relationship (Breen v Williams 1996), the Sate and its officers foreclosed from this private contract nor having any rights or obligations under it .

There is however a duty imposed on the doctor by the law of torts to answer any questions truthfully , to allow the patient to make a decision about their own lives based on current scientific data and knowledge.

In relation to the current vaccines, which have not undergone the usual lengthy and vigorous testing protocols usually over a 5-10 year period, but have been introduced and approved for use on the public in record time of about a year, with no safety or efficacy

data over any appreciable amount of time, is a fact no honest practitioner can hide from their patients. There is a duty of disclose this information.

Their mechanism of operation is not of traditional vaccines that commonly use an attenuated or killed virus to elicit a immune response. These so called “vaccines” operate in an entirely different way , so much so there is serious doubt they can even be called a vaccine at all, but the term “gene therapy “ whatever that means , may be more apt.

This fact must be explained to a patient, and they cannot be given any medication without explaining to some extent what is in them and their mode of operation. Messenger RNA “vaccines”, target a persons DNA, getting a persons own cells to make the virus or virus particles. How can this process even be regulated or turned off? Uncontrolled replication by a persons cells of the virus or parts thereof is similar to how cancer cells develop causing catastrophic results and even death.

The regulatory body “AHPRA” has attempted to silence practitioners voicing professional opinions to their patients , to abandon their legal duty to disclose information and provide advice, that is contrary to the government policy. It amounts to a form of civil conscription backed by a sanction or penalty such as de-registration.

The regulatory body must remain apolitical (Comcare v Banerji), and has no right to force or coerce the professions to aid it in a political agenda. Why didn’t AHPRA promote annual flu vaccinations?

The current data from the Department of Health since the virus was detected of “deaths” from Covid, which provide no breakdown of persons having serious underlying conditions , are showing that approximately 94 % of deaths are in the age group of 70-90 , and in the age group of 90 providing the vast majority of deaths. The data clearly shows that covid has an extremely high survival rate, so much so that death purely from it with no underlying disease is practically zero, promoting vaccination is completely disproportional to the risk of death .

The doctor is forced to enter into the voluntary contract, the doctor-patient relationship under fear, duress and coercion, to not speak the truth when there is a legal duty to do so .

Kirby J in *Wong v Commonwealth 2009 HCA*

107.To similar effect, Webb J observed[132]:To require a person to do something which he may lawfully decline to do but only at the sacrifice of the whole or a substantial part of the means of his livelihood would, I think, be to subject him to practical compulsion amounting to conscription in the case of services required by Parliament to be rendered to the people. If Parliament cannot lawfully do this directly by legal means it cannot lawfully do it indirectly by creating a situation, as distinct from merely taking advantage of one, in which the individual is left no real choice but compliance."

110.As a matter of textual interpretation of the language in which the prohibition is stated, I find it impossible to accept that the words "any form of" in s 51(xxiiiA) do not enlarge the concept of "civil conscription"[135]. They are part of the ambit of the prohibition, which is to be read as a whole. On their face, the words are clearly intended to signal that no narrow view should be taken of the form of "civil conscription" that is prohibited. **It is unpersuasive to me to draw a distinction between "compulsion to serve" and "regulation of the manner in which a service is**

performed", if such a distinction is intended to deny the fact that particular forms of regulation can, at a certain point, amount, in practice, to a "form of civil conscription". Both as a matter of textual interpretation and as a matter of practical commonsense, there is much to be said for the more ample view of the prohibition on "civil conscription" stated in the majority reasons in the *BMA* case[136]