INFORMED CONSENT AND PERFORMANCE DATA: CLINICIAN EXPERIENCE AS A MATERIAL RISK

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I INTRODUCTION

In Australia, as in other common law jurisdictions, the doctrine of informed consent has developed from the principle that individuals have a right to decide for themselves whether or not to undergo medical treatments.[1] The personal autonomy of the patient is facilitated by the provision of information by their medical practitioner. While a description in broad terms of the procedure to be performed is sufficient to establish valid consent – and to avoid the tort of trespass to the person – more information may be required to satisfy the doctor's duty to warn of a material risk, and to negate a claim of negligence.[2]

The scope and content of the duty to warn has a degree of flexibility, in that practitioners are expected to be responsive to the needs of individual patients and that this duty is subject to therapeutic privilege.[3] The focus of most informed consent discussions understandably centres on the risks of the procedure to be undertaken, and possible alternative treatment options. In recent years, however, debate has arisen both internationally and in Australia over whether the duty to warn might also encompass disclosure of risks relating to the doctor undertaking the procedure, including information about their skill or experience.[4] This debate is increasingly pressing as data pertaining to the skill and experience of individual doctors becomes more routinely collected and more widely available.

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1 See, eg, *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218, 234, 309–10 ('*Marion's Case*').

2 *Rogers v Whitaker* (1992) 175 CLR 479, 490.

3 Ibid.

4 See, eg, Emmanuel O Iheukwumere, 'Doctor, Are You Experienced? The Relevance of Disclosure of Physician Experience to a Valid Informed Consent' (2002) 18 *Journal of Contemporary Health Law and Policy* 373; Steve Clarke and Justin Oakley, 'Informed Consent and Surgeons' Performance' (2004) 29 *Journal of Medicine and Philosophy* 11 ('Informed Consent'); Richard J Veerapen, 'Informed Consent: Physician Inexperience is a Material Risk for Patients' (2007) 35 *Journal of Law, Medicine & Ethics* 478; Steve Clarke and Justin Oakley (eds), *Informed Consent and Clinician Accountability: The Ethics of Report Cards on Surgeon Performance* (Cambridge University Press, 2007).

To date, the majority of debate over the role of performance data in health care has related to surgeons and surgical outcomes. While there is no reason that other specialties could not be monitored and assessed using similar data analysis methods,[5] this article will focus on surgeons as the main example as this field currently has the most developed data collection and usage. Developments in the legal obligations of surgeons are, however, likely to have consequences for the obligations and practice of other health practitioners in the future.

As the collection, analysis and dissemination of surgical performance data becomes increasingly commonplace, it is worth determining whether, and under what circumstances, a surgeon has a duty to disclose this information to his or her patients. This article will first establish the extent to which surgical skill has been an issue in failure to warn complaints in the past, and the potential for it to be a significant future issue. The duty to warn will then be assessed with reference to statutory obligations and relevant case law. Finally, policy considerations arising from a duty to disclose performance data will be explored to identify possible future limits.

II FAILURE TO WARN AND SURGICAL SKILL

In order to assess the degree to which the general public might expect surgical skill or experience to be disclosed as part of the informed consent process, it is useful to look at patterns in complaints regarding failure to warn. Empirical studies of professional misconduct cases and negligence claims suggest that while issues with informed consent comprise a noteworthy minority of complaints against doctors, there is little evidence that surgical skill or experience constituted a reason for patient complaints within the timeframes and jurisdictions studied.[6] As Elkin and colleagues observed, the figures reported by these empirical studies do not necessarily reflect the true incidence of issues with informed consent in the medical profession as a whole, but rather are 'a function of three interrelated elements: the underlying rate of misconduct, the rate at which misconduct is reported to tribunals, and how boards and tribunals act on such reports'.[7]

As courts in Australia and internationally have increasingly moved to a standard for assessing negligence in the duty to warn that prioritises patient

5 Stephen Bolsin and Liadain Freestone, 'Report Cards and Performance Monitoring' in Steve Clarke and Justin Oakley (eds), *Informed Consent and Clinician Accountability: The Ethics of Report Cards on Surgeon Performance* (Cambridge University Press, 2007) 91.

6 Andrew J Gogos et al, 'When Informed Consent Goes Poorly: A Descriptive Study of Medical Negligence Claims and Patient Complaints' (2011) 195 *The Medical Journal of Australia* 340; Marie M Bismark et al, 'Legal Disputes over Duties to Disclose Treatment Risks to Patients: A Review of Negligence Claims and Complaints in Australia' (2012) 9 *PLOS Medicine* e1001283; Katie J Elkin et al, 'Doctors Disciplined for Professional Misconduct in Australia and New Zealand, 2000–2009' (2011) 194 *The Medical Journal of Australia* 452.

7 Elkin et al, above n 6, 455.

preferences over peer professional practice,[8] the lack of legal action described in these empirical studies might be taken as evidence that patients do not, on the whole, consider failure to disclose information relating to skill or experience a significant breach of their autonomy. However, this would be to extrapolate beyond the limits of the data. Patients can only complain about an issue of which they are aware, and these figures may simply reflect lack of public access to evidence of inadequate skill or experience. Further, the existing case law does not make it obvious that this represents a legitimate basis for litigation.

Although rare, in recent years, a few failure to warn cases have arisen in which non-disclosure of surgical skill or experience was at issue. In Australia, a number of commentators have interpreted *Chappel v Hart* (1998) 195 CLR 232 as providing support for the contention that surgeons have a duty to disclose information about their experience relative to other practitioners.[9] In this case, Dr Clive Chappel performed an operation on Mrs Beryl Hart, during which Mrs Hart's oesophagus was perforated and an infection developed, causing damage to Mrs Hart's laryngeal nerve and vocal cords. Dr Chappel was found to have performed the operation competently, and with due care and skill, although there 'was some evidence to suggest that the chance of perforation occurring was related to the degree of skill of the doctor'.[10] Mrs Hart established that damage to her voice was material to her, having expressed her concern prior to surgery that she not 'wind up like Neville Wran'[11] as the ability to speak loudly was critical to her employment.[12] She contended that, had she been warned of the risk of this outcome, she would have delayed the operation and sought the most experienced surgeon available to perform it.[13]

Gaudron J held that '[if] the foreseeable risk to Mrs Hart was the loss of an opportunity to undergo surgery at the hands of a more experienced surgeon, the duty would have been a duty to inform her that there were more experienced surgeons practising in the field'.[14] In his dissenting judgment, McHugh J observed that 'the evidence did not suggest, let alone prove, that an operation by the defendant carried with it a statistically significant greater risk of perforation than that of any other qualified surgeon'.[15] This comment suggests that any duty to disclose information about experience is only present when that experience

8 See, eg, *Canterbury v Spence*, 464 F 2d 772 (DC Cir, 1972); *Sidaway v Board of Governors of the Bethlem Royal Hospital* [1985] AC 871; *Montgomery v Lanarkshire Health Board* [2015] UKSC 11; *Rogers v Whitaker* (1992) 175 CLR 479; *Reibl v Hughes* [1980] 2 SCR 880. See also Kumaralingam Amirthalingam, 'A New Dawn for Patient's Rights?' (2001) 117 *Law Quarterly Review* 532.

9 Steve Clarke and Justin Oakley, 'Informed Consent and Surgeons' Performance' in Steve Clarke and Justin Oakley (eds), *Informed Consent and Clinician Accountability: The Ethics of Report Cards on Surgeon Performance* (Cambridge University Press, 2007) 111, 116–18 ('Surgeons' Performance'); Ian Freckelton, 'Materiality of Risk and Proficiency Assessment: The Onset of Health Care Report Cards?' (1999) 6 *Journal of Law and Medicine* 313.

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

11 Ibid 266 [91] (Kirby J).

12 Ibid 279 [105] (Hayne J).

13 Ibid 233.

14 Ibid 239 [10].

15 Ibid 250 [41].

has a quantifiable and substantial effect on the relevant risk.[16] The phrase 'statistically significant' is somewhat nebulous, in that the level of significance can be set by the user, and whether a difference is significant depends on factors such as sample size and variance. Further, statistical significance does not imply practical significance, and thus is a poor indicator – considered in isolation – of a material risk. When used in this context by a non-statistician, then, a reasonable interpretation of McHugh J's meaning would be 'clinically significant and based on quantitative evidence'.

A second case in which the experience of the treating doctor was at issue is *Brus v Australian Capital Territory* [2007] ACTSC 83. The plaintiff underwent a vaginal hysterectomy and subsequently experienced a prolapse of her right fallopian tube into her vagina through the wound, possibly as a result of the fallopian tube being caught in the suture line during the procedure. Ms Brus alleged that this complication was the result of negligence by the defendants. When it transpired that her operation had been performed by a registrar with a consultant in attendance, rather than by the consultant himself, Ms Brus amended the pleadings to include failure to inform her that the registrar would perform the operation and failure to inform her of the registrar's qualifications and experience.[17] However, Connolly J found that public hospitals did not have a duty to 'provide public patients with a choice of doctor, or to appraise a patient as to the academic standing of a registrar'.[18] Hospitals do, however, have a duty to provide 'suitably qualified staff'.[19] The existence of this duty arguably introduces some tension if there is no similar duty on an individual doctor; albeit that the duty may be not to offer the service, rather than to disclose information about skill in performing the service. Connolly J distinguished this case from *Chappel v Hart* on the basis that 'the unusual facts of this case' made it inappropriate: the negligence was found not in a failure to warn, as she was found to have been informed that a registrar might perform the operation, but rather in the hospital allowing the registrar to act as a 'level 3' trainee when she actually possessed the skills of a 'level 2' trainee.[20] Surgical skill and experience was therefore significant only insofar as it accorded with the skill and experience expected of a person employed in a particular role. On that basis, a similar complaint could potentially be made against a hospital that employed a surgeon known to have a complication rate substantially higher than their peers.

While both *Chappel v Hart* and *Brus v Australian Capital Territory* discussed surgical skill and experience in terms of years served in surgical employment, *G & C v Down* [2008] SADC 135 is notable for using adverse event rates as a measure of skill. The first plaintiff, having decided not to have any more children, sought a tubal ligation from the defendant. During the consultation, the defendant explained the procedure and described the risk of

16 Bill Madden and Janine McIlwraith, *Australian Medical Liability* (LexisNexis, 2nd ed, 2013) 38.
17 *Brus v Australian Capital Territory* [2007] ACTSC 83, [9] (Connolly J).
18 Ibid [62].
19 Ibid.
20 *Brus v Australian Capital Territory* [2007] ACTSC 83, [61]–[62].

failure (ie, future pregnancy) as one in 2000.[21] This figure was based on his own experience; Dr Down had performed approximately 2000 tubal ligations and had never received a report of a failure from his patients.[22] A pamphlet published by the Royal Australian College of Obstetricians and Gynaecologists, on the other hand, quantified the risk of becoming pregnant following tubal ligation surgery as approximately one in 500,[23] and failure rate statistics published in the literature ranged between one in 500 to one in 1000.[24] Robertson J found that Dr Down had breached his duty of care by not making it clear that the quoted failure rate was his own experience, noting that '[t]he personal experience of the gynaecologist would be of great significance to the patient'.[25]

Further, Robertson J stated that:

> I am also of the opinion that where the numerical ratio of the gynaecologist's personal failure rate is conveyed, either in response to questioning by the patient or being volunteered by the gynaecologist, then in order to provide a proper balance for the patient, the literature failure rate should be conveyed. The picture would not be complete otherwise.[26]

Dr Down's personal failure rate was allegedly lower than the published rate, and it is unclear from Robertson J's reasoning whether a surgeon with a failure rate higher than the published average would have a duty to disclose their own experience or whether citing the published figures would meet the standard required.

The extent to which surgeons have a duty to disclose their experience, including rates of complication, with a particular procedure was considered as part of a wider case alleging a failure to warn of a material risk of a surgical procedure in *Morocz v Marshman*.[27] Maria Morocz consulted Dr Marshman regarding treatment of her hyperhidrosis, for which Dr Marshman subsequently performed a bilateral endoscopic thoracic sympathectomy on Ms Morocz.[28] Ms Morocz experienced a range of complications following the surgery, and alleged that Dr Marshman had failed to warn her of these potential outcomes.[29] In particular, she alleged that he failed to advise her '[of] his own experience with sympathectomy procedures, including rates of complication'.[30]

Harrison J described this as a 'curious allegation':

> Ms Morocz did not ask Dr Marshman for his surgical track record performing bilateral endoscopic thoracic sympathectomies, or about his rates of success, however that concept might be measured, or about his rates of occurrence of particular post-operative complications. It would have been surprising had she done so. It is in my opinion even more surprising that Ms Morocz now alleges that Dr Marshman had some unspecified obligation to reveal to her his surgical history

21 *G & C v Down* [2008] SADC 135, [49]–[51], [61] (Robertson J).
22 Ibid [61] (Robertson J).
23 Ibid [64]–[65] (Robertson J).
24 Ibid [84] (Robertson J).
25 Ibid [140].
26 Ibid [141].
27 [2015] NSWSC 325. See also *Morocz v Marshman* [2016] NSWCA 202.
28 *Morocz v Marshman* [2015] NSWSC 325, [1]–[2], [8] (Harrison J).
29 Ibid [67] (Harrison J).
30 Ibid.

> performing this operation. Dr Marshman was a duly qualified medical practitioner with a certified specialty and entitled to practice as such. It was not his obligation to volunteer information of the kind in question. He would have been entitled to refuse to provide it if asked.[31]

Three interesting points arise from this judgment. First, the statement that it would have been 'surprising' for Ms Morocz to ask about Dr Marshman's experience suggests that a surgeon's experience would not usually be material to a patient. This is in opposition to Robertson J's comment in *G & C v Down*, describing surgical experience as 'of great significance to the patient'.[32] Secondly, Harrison J appears to be in agreement with the judgment in *Brus v Australian Capital Territory*, that a doctor need only be appropriately qualified, and that there exists no further duty to disclose information relating to skill or experience. Thirdly, the statement that Dr Marshman 'would have been entitled to refuse … if asked' to disclose such information seems to go further than previous judgments. It is unclear on what basis Harrison J made this statement. One possibility is therapeutic privilege, which allows that a doctor would be justified in withholding information or from volunteering information where they reasonably believe that the information might seriously harm a patient's mental or physical health, or that a patient would be unable to make a rational decision using the information because of their temperament or emotional state.[33] However, therapeutic privilege has been quite narrowly interpreted,[34] excluding elective surgical procedures, limiting its application in this situation. The limits of therapeutic privilege were further delineated in *Montgomery v Lanarkshire Health Board*, in which Lords Kerr and Reed made clear that:

> It is a limited exception to the general principle that the patient should make the decision whether to undergo a proposed course of treatment: it is not intended to subvert that principle by enabling the doctor to prevent the patient from making an informed choice where she is liable to make a choice which the doctor considers to be contrary to her best interests.[35]

Internationally, there are very few cases addressing the issue of surgical experience and informed consent. One that explicitly considered experience in quantitative terms was *Johnson v Kokemoor*, 545 NW 2d 495 (Wis, 1996). The defendant surgeon in this case exaggerated his experience with aneurysm surgery and, despite reviewing the literature prior to the surgery, suggested to the plaintiff that the morbidity and mortality risks were around two per cent rather than the 15 per cent reported in the literature.[36] Further, expert evidence indicated that risks closer to 30 per cent could be expected from a surgeon with the defendant's experience.

The defendant argued that a doctor had a duty to disclose only those risks inherent in the treatment, and that evidence relating to his skill and experience

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31 Ibid [192].
32 [2008] SADC 135, [140].
33 *F v R* (1983) 33 SASR 189, 193 (King CJ).
34 See, eg, *Tai v Saxon* (unreported, Supreme Court of Western Australia, Pidgeon, Franklyn and Ipp JJ, 8 February 1996).
35 [2015] UKSC 11, [91].
36 *Johnson v Kokemoor*, 545 NW 2d 495, [624]–[626] (Abrahamson J) (Wis, 1996).

was irrelevant and prejudicial.[37] The court rejected this, instead emphasising that the information to be disclosed was context-specific and that, in this case, 'had a reasonable person in her position been aware of the defendant's relative lack of experience in performing basilar bifurcation aneurysm surgery, that person would not have undergone surgery with him'.[38] However, the judgment made it clear that 'our decision will not always require physicians to give patients comparative risk evidence in statistical terms to obtain informed consent'.[39]

Iheukwumere has noted that the effect of *Johnson v Kokemoor* on subsequent decisions in other United States ('US') jurisdictions was mixed, with many maintaining that only risks inherent to the treatment could be material and others acknowledging that external risks, including those relating to the surgeon, could constitute a material risk, particularly in cases where the patient expressed a specific interest in such risks.[40]

There is therefore little evidence to suggest that practitioner-specific performance measures currently form part of the disclosure obligation. Most considerations have been obiter dicta, and when considered directly, courts have been reluctant to extend a general duty to disclose information relating to skill and experience.

III TRENDS IN PUBLICATION OF PERFORMANCE DATA

It is possible that the apparent dearth of cases addressing this issue reflects the fact that, in most instances, patients do not have access to the relevant information, and so cannot attribute negative surgical outcomes to the skill (or lack of skill) of their surgeon. Further, it might be expected that a surgeon's skill as measured by peer or patient opinion would be more difficult to use as a basis for complaint than quantitative measures of performance. In the cases discussed above, this information was generally uncovered once a complaint had been made on other grounds, leading to inclusion of non-disclosure of surgical skill as a minor component of the overall claim. There are, however, grounds for anticipating significant change in this situation.

The collection and analysis of surgical outcome data is not a recent innovation; modern practice traces its descent from nineteenth century reform efforts. Spiegelhalter identified two main philosophies of surgical audit: the 'epidemiological' approach, introduced by Florence Nightingale and presenting summary statistics for the comparison of hospitals by disease, injury, age of patient, and district; and the 'clinical' approach, advocated by Ernest Codman, in which peer review of case histories is used to identify sources of surgical error.[41]

37 Ibid [637] (Abrahamson J).
38 Ibid [641] (Abrahamson J).
39 Ibid [646] (Abrahamson J).
40 Iheukwumere, above n 4, 407–13.
41 David J Spiegelhalter, 'Surgical Audit: Statistical Lessons from Nightingale and Codman' (1999) 162 *Journal of the Royal Statistical Society: Series A (Statistics in Society)* 45.

Both approaches have their limitations, recognised since their inception. Epidemiological audits require adjustment for case mix, are susceptible to data manipulation, and tend to focus on single outcome measures (such as mortality, or readmission) that imperfectly reflect the 'success' of the operation.[42] Clinical audits, on the other hand, focus on individual events and are difficult to draw generalisable conclusions from, as sample sizes are small and denominator data is frequently missing, and tend to focus on events with catastrophic outcomes, thus potentially missing wider patterns of substandard, but non-lethal, practice.[43] In both approaches, easily measured outcomes such as mortality or revision are the focus, although this can skew perceptions of surgical 'success' away from factors that may be considered more pertinent by patients, such as pain, functionality, quality of life, or the communication skills or availability of the surgeon.[44]

Nevertheless, both approaches are still in use in modern health care. For example, the clinical approach is still evident in hospitals across Australia, where root cause analyses are triggered by clinical incidents with the highest severity rating.[45] The epidemiological approach, on the other hand, is extensively utilised by the colleges and other medical and surgical organisations in surgical audits[46] and registers, such as the National Joint Replacement Registry maintained by the Australian Orthopaedic Association.[47] As technology and analytical capabilities have improved, the datasets resulting from these activities have been able to be linked for research, quality improvement or regulatory purposes.[48] The significant development in recent times is that data of this kind is increasingly being made public and, in some instances, identifiable at the level of individual surgeons.

The precedent for public reporting of surgical data comes from the US, with many of the early examples involving cardiac surgery and associated clinical data registries.[49] Data from the New York State Department of Health was made public when *Newsday* used the freedom of information law to access and then publish data on the mortality rates of individual surgeons.[50] With a demonstrated public appetite for information about clinical expertise and outcomes, several online systems have appeared in recent years, including: Medicare's Physician Compare; Consumers' Checkbook's Surgeon Scorecard; and Propublica's

42 Ibid 49.
43 Ibid 52.
44 Ian Harris, *Surgery, the Ultimate Placebo* (NewSouth Publishing, 2016) 30–2.
45 Jonny Taitz et al, 'System-Wide Learning from Root Cause Analysis: A Report from the New South Wales Root Cause Analysis Review Committee' (2010) 19 *Quality & Safety in Health Care* e63.
46 Most notably the Australian and New Zealand Audits of Surgical Mortality: Royal Australasian College of Surgeons, 'Australian and New Zealand Audit of Surgical Mortality: National Report 2014' (2014) <http://www.surgeons.org/media/22243780/2015-11-23_rpt_anzasm_report_2014.pdf>.
47 Australian Orthopaedic Association, *National Joint Replacement Registry* <https://aoanjrr.sahmri.com/home>.
48 Bolsin and Freestone, above n 5, 94–6.
49 David M Shahian et al, 'Public Reporting of Cardiac Surgery Performance: Part 1 – History, Rationale, Consequences' (2011) 92 *Annals of Thoracic Surgery* S2, S3.
50 David L Brown, Stephen Clarke and Justin Oakley, 'Cardiac Surgeon Report Cards, Referral for Cardiac Surgery, and the Ethical Responsibilities of Cardiologists' (2012) 59 *Journal of the American College of Cardiology* 2378, 2378.

Surgeon Scorecard.[51] Increasing availability has given rise to a degree of acceptance within the medical fraternity that '[e]very patient has a right to know about his or her clinician's expertise and outcomes'.[52]

In the United Kingdom ('UK'), the public inquiry into paediatric cardiac surgery at the Bristol Royal Infirmary resulted in 198 recommendations, of which two advised that patients should have access to information about the performance of the trust, the hospital, and the specialist.[53] It further proposed that publication of such information should be a regular feature of children's health care services.[54] It has been argued that this 'led to an increasing belief that the interests of the public and patients would be served by publication of individuals' surgical performance in the form of postoperative mortality'.[55] Since the events at Bristol, surgeon-specific outcomes have become increasingly transparent, with voluntary reporting by the Society of Cardiothoracic Surgeons of Great Britain and Ireland in 2004, by the *Guardian* under the *Freedom of Information Act 2000* (UK) in 2005, and the *Everyone Counts* planning document in the wake of events at the Mid-Staffordshire Hospital in 2012, which resulted in the National Health Service ('NHS') Mandate requirement to publish at the consultant level.[56]

Australian practice has lagged behind that of the US and the UK, although there is evidence that practice here is following international precedent. As in the UK, scandals often provide the stimulus for reform within the Australian health care system. A review of recent events at Djerriwarrh Health Services at Bacchus Marsh in Victoria, in which a cluster of preventable perinatal deaths was belatedly identified, recommended increased auditing and reporting of maternity performance indicators.[57] In addition to prompting improvements in the use of outcome data for monitoring purposes, the events at Bacchus Marsh may also provide fresh impetus for public reporting of performance data.

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51 Aria A Razmaria and Edward H Livingston, 'How to Use Online Clinician Rating Systems' (2015) 314 *JAMA* 1418. See: US Centers for Medicaid & Medicare Services, *Physician Compare*, Medicare.gov <www.medicare.gov/physiciancompare/search.html>; Consumers' Checkbook, *Surgeon Ratings* <www.checkbook.org/surgeonratings>; Sisi Wei, Olga Pierce and Marshall Allen, *Surgeon Scorecard* (15 July 2015) ProPublica <projects.propublica.org/surgeons>.

52 Razmaria and Livingston, above n 51, 1418.

53 The Bristol Royal Infirmary Inquiry, *Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995*, Cm 5207(I) (2001) 441, 456.

54 Ibid 458.

55 Bruce Keogh et al, 'The Legacy of Bristol: Public Disclosure of Individual Surgeons' Results' (2004) 329 *BMJ* 450, 450.

56 P D Radford et al, 'Publication of Surgeon Specific Outcome Data: A Review of Implementation, Controversies and the Potential Impact on Surgical Training' (2015) 13 *International Journal of Surgery* 211; 'Heart Surgery Data: Non Risk Adjusted' *The Guardian* (online), 16 March 2005 <https://www.theguardian.com/society/2005/mar/16/NHS2>; National Health Service England, *Everyone Counts: Planning for Patients 2013/14* (17 December 2012) <https://www.england.nhs.uk/2012/12/everyonecounts/>; National Health Service, *Public Health Outcomes Framework* (February 2017) My NHS <https://www.nhs.uk/service-search/performance/Consultants#view-the-data>.

57 Debora Picone and Kieran Pehm, 'Review of the Department of Health and Human Services' Management of a Critical Issue at Djerriwarrh Health Services' (Report, Australian Commission on Safety and Quality in Health Care, November 2015) <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/djerriwarrh>; Euan M Wallace, 'Report of an Investigation into Perinatal Outcomes at Djerriwarrh Health Services' (Executive Summary, 31 May 2015) <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/djerriwarrh>.

The influence of domestic and international events is evident in efforts at greater transparency by the Royal Australasian College of Surgeons through publication of annual reports of surgical mortality[58] and a nascent collaboration with private health insurer Medibank to publish surgical variance reports.[59] Taken in the context of international developments, the College's moves towards increasing transparency perhaps reflect an awareness that if they do not take the initiative in analysing and presenting available data to the public, the data may be taken out of their hands and presented in ways that might be considered inimical to the interests of the profession, or the health system more widely. Indeed, this may already be occurring: health insurers nib, Bupa and HBF have initiated a collaboration to extend the health care directory Whitecoat to include fee information and customer reviews of medical specialists.[60] Significantly, Mark Fitzgibbon, Chief Executive Officer of nib, indicated that the eventual goal was 'to publish the clinical outcomes of specialists from hospital data, adjusted for variables such as some doctors taking on more difficult cases', citing 'information asymmetry' between providers and consumers greater than other markets as a motivating factor.[61]

In this context, an increase in future failure to warn cases relating to surgical skill and performance data appears probable. Adding further momentum to this movement are ethical arguments, not just for increased public reporting, but for an obligation to disclose performance data as part of informed consent. Clarke and Oakley argued that a surgeon's performance ability is one of the most influential factors in the success of an operation, that it represents a foreseeable risk, and that it is both quantifiable and easily accessible for individual surgeons.[62] According to Clarke and Oakley, it therefore constitutes a material risk and should be disclosed to patients in order to facilitate their autonomy. They considered years of experience (as used in *Chappel v Hart*) to be a poor marker of skill, and recommended surgeon report cards as a superior source of data and argued that surgeons should disclose success and complication data for the procedure comparing themselves to the average of their colleagues.[63] The few cases that have arisen in recent years may not be aberrations, but rather the beginnings of a wider trend. For that reason, it is worth examining the legal basis on which such claims might rest.

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58 See, eg, the most recent published report: Royal Australasian College of Surgeons, above n 46.

59 The first of a planned series was published last year: Royal Australasian College of Surgeons and Medibank, 'Surgical Variance Report: General Surgery' (April 2016) <https://www.surgeons.org/media/24091469/Surgical-Variance-Report-General-Surgery.pdf>.

60 Whitecoat, 'Nib, Bupa and HBF to Form Whitecoat Healthcare Directory Joint Venture' (Media Release, 29 July 2016) <https://www.whitecoat.com.au/blog/media-release-29th-july-2016>.

61 Harriet Alexander, 'Health Insurance Companies Encourage Consumers to Rate Doctors on New Website', *The Age* (online), 29 July 2016 <http://www.theage.com.au/business/consumer-affairs/health-insurance-companies-encourage-consumers-to-rate-doctors-on-new-website-20160728-gqfldo>.

62 Clarke and Oakley, 'Informed Consent', above n 4, 12–15.

63 Ibid 18–19. See also Clarke and Oakley, 'Surgeons' Performance', above n 9.

IV DUTY TO WARN

The cases considered to date provide little consistent guidance to health practitioners on the appropriateness of including surgical skill and experience within the duty to warn. In considering emergent failure to warn cases relating to surgical performance data, the issues must first be addressed with reference to the civil liability legislation and then to precedent from common law.

A Statutory Framework

In response to a perceived crisis in the rising costs of personal liability insurance and its effect on insurance availability, in 2002 the Commonwealth, state and territory governments appointed a four-person panel to review the law of negligence ('the Panel').[64] The final report of the Panel included substantial consideration of professional liability, including specific reference to medical professionals.[65] The Ipp Report strongly influenced the subsequent legislative reform of tort law in Australia, but was by no means adopted in its entirety. Significantly, the first recommendation of the Panel was that reform should be nationally consistent, yet the civil liability Acts[66] that resulted (either as new statutes or amended existing legislation) contained a range of inconsistencies, limiting the ability of decisions in one state or territory to inform decisions in the others.[67]

Regarding the duty to warn, the recommendations of the Panel were strongly influenced by Australian precedent and took the position that issues around informed consent could be guided by evidence of peer professional opinion, but ultimately were for the courts to decide.[68] The Ipp Report emphasised that informed consent was about facilitating patient autonomy and in doing so, reaffirmed the shift observed in many countries from a practitioner-centred standard for assessing failure to warn to a patient-centred standard.[69]

However, the Ipp Report noted that the content and scope of the duty to warn should not solely be determined with reference to a patient-centred standard, but should be viewed as 'a duty to take reasonable care to inform', and 'that consideration must be given to the situation of the practitioner'.[70] This caveat was to ensure that practitioners did not experience an unreasonable burden or

64 David Andrew Ipp et al, 'Review of the Law of Negligence' (Final Report, September 2002) ('Ipp Report') <http://www.treasury.gov.au/ConsultationsandReviews/Reviews/2002/~/media/Treasury/Consultations%20and%20Reviews/Reviews%20and%20Inquiries/2002/Review%20of%20the%20Law%20of%20Negligence/Key%20Documents/PDF/Law_Neg_Final.ashx>.

65 Ibid 37–57.

66 *Civil Law (Wrongs) Act 2002* (ACT); *Civil Liability Act 2002* (NSW); *Personal Injuries (Liabilities and Damages) Act 2003* (NT); *Civil Liability Act 2003* (Qld); *Civil Liability Act 1936* (SA); *Civil Liability Act 2002* (Tas); *Wrongs Act 1958* (Vic); *Civil Liability Act 2002* (WA).

67 Barbara McDonald, 'Legislative Intervention in the Law of Negligence: The Common Law, Statutory Interpretation and Tort Reform in Australia' (2005) 27 *Sydney Law Review* 443, 481.

68 Ipp et al, above n 64, 45.

69 Clarke and Oakley, 'Surgeons' Performance', above n 9; Freckelton, above n 9.

70 Ipp et al, above n 64, 47.

'unrealistic standards of behaviour'.[71] Thus, Recommendation 6 was that the nature of the duty to warn should be expressed as a duty to take reasonable care, and Recommendation 7 advised that two types of duty to warn should be recognised: a proactive duty (addressing what a reasonable patient would want to know) and a reactive duty (addressing what the practitioner knows, or ought to know, that a particular patient wants to know).[72] Tasmania, Queensland and Victoria included provisions that enacted these recommendations,[73] although the remaining states and territories effectively achieve the same ends by relying on the principle established in common law.[74] The Panel further suggested that a practitioner should not breach a proactive duty if the risk they failed to disclose was 'obvious',[75] but only Tasmania and Queensland enacted such a provision.[76]

Each of the states (but neither of the territories) included enactments regarding the standard of care to be used in assessing professional negligence in relation to treatment that referred to peer professional opinion, and each also enacted provisions that made it clear that this standard was not to be used in assessing failure to warn.[77]

The Ipp Report noted that determining the specific information to be imparted by practitioners to their patients was difficult, concluding that '[w]hat types of information are required to be given will depend on the circumstances of each case, and it is not possible or desirable to make general provision about this matter'.[78] The Panel did, however, acknowledge that practitioners desired greater guidance, in order to avoid liability for negligence.[79] It had been suggested that guidelines formulated by Colleges or the National Health and Medical Research Council might articulate the necessary information more fully. The Panel's view was that 'while compliance (or non-compliance) with such advisory regimes would (in accordance with current law) be relevant to the legal issue of reasonable care, it could never be treated as conclusive of the issue'.[80] In this, the Panel echoed the majority judgment in *Rogers v Whitaker*:

> 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 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'.[81]

This view is of particular current interest, as the Medical Board of Australia has recently published 'Guidelines for Registered Medical Practitioners

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71 Ibid.
72 Ibid 2–3.
73 *Civil Liability Act 2002* (Tas) s 21; *Civil Liability Act 2003* (Qld) s 21; *Wrongs Act 1958* (Vic) s 50.
74 See discussion below, in Part IV(B).
75 Ipp et al, above n 64, 51–2.
76 *Civil Liability Act 2002* (Tas) s 17; *Civil Liability Act 2003* (Qld) s 15.
77 *Civil Liability Act 2002* (NSW) s 5P; *Civil Liability Act 2003* (Qld) s 22; *Civil Liability Act 1936* (SA) s 41; *Civil Liability Act 2002* (Tas) s 22; *Wrongs Act 1958* (Vic) s 60; *Civil Liability Act 2002* (WA) s 5PB.
78 Ipp et al, above n 64, 48.
79 Ibid 49.
80 Ibid 50.
81 (1992) 175 CLR 479, 487 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).

Who Perform Cosmetic Medical and Surgical Procedures'.[82] Information that the medical practitioner must provide to the patient is outlined in section 4.1, and includes 'the medical practitioner's qualifications and experience'. Developed under section 39 of the Health Practitioner Regulation National Law,[83] these guidelines are, under section 41, 'admissible in proceedings under this Law or a law of a co-regulatory jurisdiction against a practitioner by the Board as evidence of what constitutes appropriate professional conduct or practice for the profession'.[84] Beyond this explicit use in proceedings relating to registration, guidelines such as these have the potential to prove useful, though not decisive, in establishing negligence in failure to warn cases.

The Panel made a number of observations that were not subsequently enacted as part of the civil liability Acts. Relevantly, the Ipp Report commented that '[it] seems clear that the proactive duty to inform is not confined to information about risks but extends to other types of information that may be needed to enable patients to make an informed decision about their health'.[85] In saying this, the Panel explicitly recognised that information beyond the risks inherent in the proposed treatment could be validly considered material. Further, they noted that:

> A specific issue raised in the course of the Panel's consultations is whether the proactive duty to inform requires the practitioner to tell the prospective patient that the treatment is also available from other more skilled or experienced practitioners. This question cannot be answered in the abstract. Although, generally, such an obligation would not arise, there might be exceptional circumstances in which it would. It would be neither desirable nor practicable to attempt to spell these out in legislative form.[86]

It is clear that the Panel envisaged a substantial continued role for the common law in the development of legal principles in negligence, and specifically regarding the issue of whether practitioners have a duty to disclose information relating to their experience or skill. From the fact that no provisions were enacted in any of the civil liability Acts that addressed this issue, it may be inferred that legislators concurred with the Panel's position and preferred that it be left to the common law to develop appropriate principles.

McDonald observed that some provisions of the civil liability Acts 'merely restate[d] the common law or [set] out a position that the common law had already reached'.[87] Further, she noted that '[m]any critical issues and questions in

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82 Medical Board of Australia, 'Guidelines for Registered Medical Practitioners Who Perform Cosmetic Medical and Surgical Procedures' (1 October 2016) <http://www.medicalboard.gov.au/News/2016-05-09-media-statement.aspx>.

83 The National Registration and Accreditation Scheme is enacted by state and territory based legislation: *Health Practitioner Regulation National Law (ACT) Act 2010* (ACT); *Health Practitioner Regulation (Adoption of National Law) Act 2009* (NSW); *Health Practitioner Regulation National Law Act 2009* (Qld); *Health Practitioner Regulation (National Uniform Legislation) Act 2010* (NT); *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA); *Health Practitioner Regulation National Law (Tasmania) Act 2010* (Tas); *Health Practitioner Regulation National Law (Victoria) Act 2009* (Vic); *Health Practitioner Regulation National Law (WA) Act 2010* (WA).

84 Medical Board of Australia, 'Guidelines', above n 82, 2.

85 Ipp et al, above n 64, 48.

86 Ibid 50.

87 McDonald, above n 67, 460.

negligence and tort law remain wholly or partly untouched by this legislation and require further development and elucidation by the courts',[88] of which the role of a surgeon's experience and skill in informed consent constituted one such issue. For these reasons, and to aid in the interpretation of the statutory provisions, reference to common law cases remains indispensable within medical negligence.

B Common Law

In Australia, the standard of care to be taken by medical practitioners in the provision of professional advice and treatment is that of reasonable care and skill.[89] While reasonable care and skill in treatment can be determined with reference to peer professional opinion, the appropriate standard of care in the provision of advice is ultimately for the courts, not the medical profession, to decide.[90] As King CJ noted in *F v R*, the information a medical practitioner is required to disclose to a patient will be context-specific:

> What a careful and responsible doctor would disclose depends upon the circumstances. The relevant circumstances include 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.[91]

This passage was cited with approval by the majority in *Rogers v Whitaker*.[92] Mason CJ, Brennan, Dawson, Toohey and McHugh JJ's joint judgment further articulated a doctor's duty to warn:

> 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 be reasonably aware that the particular patient, if warned of the risk, would be likely to attach significance to it.[93]

The phrasing here suggests that there is a distinction to be made between risks inherent in the treatment and risks external to the treatment, with the latter not considered part of the duty to warn. Iheukwumere, for example, argued that this distinction provided the basis for differences between US jurisdictions in the wake of *Johnson v Kokemoor*.[94] In the Australian context, however, this may be more of a red herring: *Chappel v Hart* found a duty to disclose a risk that was not inherent to the procedure (although it may be argued that risks relating to the surgeon are inherent to any surgical procedure) and the Panel explicitly acknowledged that where information beyond traditionally understood risks was

88 Ibid 481.
89 *Rogers v Whitaker* (1992) 175 CLR 479, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).
90 *F v R* (1983) 33 SASR 189, 194 (King CJ), approved in *Rogers v Whitaker* (1992) 175 CLR 479, 488–9 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).
91 (1983) 33 SASR 189, 192 (King CJ).
92 (1992) 175 CLR 479, 488 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ).
93 Ibid 490.
94 Iheukwumere, above n 4, 407–13.

needed for a patient to make an informed decision, that information would form part of the duty to inform.[95]

The test of materiality outlined in *Rogers v Whitaker* is divided into an objective limb (the hypothetical reasonable person) and a subjective limb (the particular patient, with all their idiosyncrasies).[96] This division echoes the proactive and reactive duties recognised in the Ipp Report recommendations. Both are subject to therapeutic privilege, although the precise extent of this has not been clearly defined.[97]

With respect to the objective test, it might appear that a case could be made for 'a reasonable person in the patient's position' to attach significance to information about their surgeon's skill or experience. Certainly, the increasing interest in public reporting of performance data at the level of individual surgeons speaks to this being an issue of widespread societal significance. The intuitive appeal of this position was acknowledged by Robertson J in *G & C v Down*,[98] although Harrison J would have evinced 'surprise' had Ms Morocz expressed such interest.[99]

Significantly, Gummow J viewed King CJ's articulation of the five relevant circumstances influencing the information to be disclosed as a reformulation of the criteria for determining breach of duty expressed by Mason J in *Wyong Shire Council v Shirt*:

> 'the magnitude of the risk and the degree of the probability of its occurrence', balanced against 'the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities which the defendant may have'.[100]

Viewed in this way, the fact that most people would be likely to attach significance to information about their surgeon's experience or skill is not sufficient in itself to establish it as material. The information needs also to convey some level of risk that is not outweighed by the costs involved in communicating that information.

This crux issue is perhaps the basis for the Panel's position that 'generally … an obligation' to disclose performance data 'would not arise', although 'there might be exceptional circumstances in which it would'.[101] For the average patient, it could be assumed that a surgeon whose performance was within a range deemed acceptable and competent practice does not present a risk of sufficient magnitude or probability. In most cases, the performance data of the surgeon in question will be within the limits of acceptable practice. Occasionally, it will reveal exceptional practice. And sometimes it will provide evidence of substandard or dangerous practice. Such practitioners should not merely be

95 Ipp et al, above n 64, 48.

96 (1992) 175 CLR 479, 490 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ). The objective and subjective elements of the test of materiality were confirmed and developed in *Rosenberg v Percival* (2001) 205 CLR 434, 500 [210] (Callinan J).

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

98 [2008] SADC 135, [140].

99 *Morocz v Marshman* [2015] NSWSC 325, [192].

100 *Rosenberg v Percival* (2001) 205 CLR 434, 458 [76] (Gummow J), citing Mason J in *Wyong Shire Council v Shirt* (1980) 146 CLR 40, 47–8.

101 Ipp et al, above n 64, 50.

disclosing this information to their patients, they should be receiving performance management, retraining or be removed from practice entirely. For most patients, a 'duly qualified medical practitioner' is sufficient.[102] However, in some cases the performance will convey information that describes a risk that is of practical significance – and therefore a material risk – to particular patients.

The threshold for sufficient magnitude or probability is such that the risk conveyed by the information would outweigh the costs of disclosure. In the objective test, the costs would be: the extra time and expense involved in disclosing performance data to every single patient; costs associated with collection, analysis and dissemination of valid and reliable data; and costs associated with the impact systematic disclosure would have on resource allocation, hospital waiting lists and training of junior doctors.

These costs are clearly significant. In the past, it was clear that costs associated with systematic disclosure of performance data greatly outweighed the potential risk for the average patient. However, this equation is not static, and as the variables change over time, it will require revisiting. The costs of data collection, analysis and dissemination are rapidly falling, as technology advances and as performance data is integrated into standardised administrative functions. With better quality data at their fingertips, surgeons are increasingly well-placed to share this data with their patients in a time and cost-efficient manner, as they are less likely to need to provide extensive context to account for inappropriately adjusted risk statistics or to rely on qualitative measures of performance. Although it is not currently part of standard professional practice to disclose performance data,[103] and effecting widespread change in professional practice may be expected to be slow and expensive, the recent guidelines for cosmetic surgery[104] suggest that such change is not considered an insurmountable problem by the medical profession. Once established in one subsection of the profession, it may extend more easily to the remainder. Further, this change may prove influential in the courts' consideration of future cases. At present, the costs to the health care system more widely probably still exceed the putative risks to patients, although this too is likely to vary with time as the health care system itself evolves to meet these and other challenges.[105]

It is reasonable to conclude, therefore, that no objective duty currently exists for surgeons to disclose performance data to their patients, although the

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102 *Morocz v Marshman* [2015] NSWSC 325, [192] (Harrison J).

103 A sub-disciplinary exception to this rule is the publication of success rates by in-vitro fertilisation clinics on their websites. A recent investigation by the Australian Competition and Consumer Commission ('ACCC'), following a complaint from the Australian Health Practitioner Regulation Agency, found that 'some made success-rate comparisons without adequate disclosure about, or qualification of, the nature of the data or graphics used to make the claim': Australian Competition and Consumer Commission, 'IVF "Success Rate" Claims Under the Microscope' (Media Release, MR 212/16, 14 November 2016) <http://www.accc.gov.au/media-release/ivf-success-rate-claims-under-the-microscope>.

104 Medical Board of Australia, 'Guidelines', above n 82.

105 Clarke and Oakley anticipated some of these costs in their analysis of the ethical obligation to disclose performance data, and suggested some possible solutions, although they noted that this was an issue 'which each community would have to confront for themselves, with reference to the particular health care system in place there': 'Informed Consent', above n 4, 29.

possibility remains that such a duty may arise in the future. Were such a duty imposed, a key area for clarification would be the content of a workable duty. For example, it is currently uncertain whether it would be sufficient to convey that a practitioner's performance was above a threshold of acceptable practice, or whether it would be necessary to disclose how a practitioner compared to his or her colleagues. The implication of *G & C v Down* is that any information provided to patients about a particular practitioner needs to be contextualised, at least with reference to published professional averages.[106] Whether such contextual information would extend to explicit comparisons between practitioners, or ranking of practitioners, is less clear. Empirical research into what information patients value most would support the development of this area.

In considering the subjective test, a case can much more easily be made for a particular patient attaching significance to information about their surgeon's experience or skill. Indeed, *Chappel v Hart* provides a clear such example.[107] Recent media reports further support the contention that some patients believe knowledge of their surgeon's history to be relevant to the process of deciding to undertake a procedure.[108] Given the increasing ease with which surgeons have access to data regarding their performance across a range of outcomes, and the concomitant ease with which they can compare it to the performance data of their colleagues, the costs of disclosing this data to patients who specifically ask for it, exhibit particular anxiety, or otherwise demonstrates that they would attach a level of significance to the information above that of the average patient, could easily be less than the risk conveyed by the information.

In particular, the patients of a surgeon whose adverse outcomes for a specific procedure vary substantially from the mean or the published rates could reasonably be expected to consider such information material, especially when substantially worse than average. A duty to disclose this information to all patients for that procedure may arguably exist. The social utility of the procedure may also be relevant when evaluating risks and costs of disclosure, in that procedures of lower social utility (such as some cosmetic surgery) may require a greater range of information to be disclosed for patient autonomy to be facilitated than interventions of higher social utility (such as surgery restoring use of a limb).

More importantly, the decisional causation aspect of disclosure cases is likely to be most influential in practice, by eliminating a substantial proportion of cases in which inadequate information has been provided. Given the recent trend towards tightening of causation in medical negligence cases,[109] it will be challenging for plaintiffs to prove on a balance of probabilities that an alternative care path would have been taken had the additional information been provided,

106 [2008] SADC 135, [141] (Robertson J).

107 (1998) 195 CLR 232.

108 Sophie Scott and Rebecca Armitage, 'Patient Whose Breast "Exploded" After Implant Surgery Calls for Greater Transparency of Doctor's History', *ABC News* (online), 10 August 2016 <http://www.abc.net.au/news/2016-08-10/calls-for-transparency-of-doctors-legal-settlement-history/7704520>.

109 See, eg, *Wallace v Kam* (2013) 250 CLR 375.

particularly in cases involving emergent or urgent treatments. Further, there is some evidence from the empirical health services literature that patients do not tend to use publicly available performance data, and even practitioners' referral recommendations are largely uninfluenced by such data.[110] This seems to be at least partly a result of a lack of trust in the reliability and validity of publicly reported performance data, and so it is not clear whether performance data from a more trusted source would be more influential in patient decision-making.

The reluctance of the courts in *Brus v Australian Capital Territory* and *Morocz v Marshman* to find that the practitioners had a duty to disclose information about qualifications or experience is congruent with the objective test as outlined above. Neither plaintiff specifically asked for such information or demonstrated particular anxiety, and therefore the respective defendants had no reason to believe the information to hold particular significance for their patients. Conversely, in *Johnson v Kokemoor*, the patient explicitly pressed the practitioner on his experience performing surgery on aneurysms like hers; a clear case for disclosure can be made under the subjective test in this example.[111] However, the subjective test renders somewhat surprising Harrison J's comment in *Morocz v Marshman* that Dr Marshman would have been entitled to refuse to disclose his experience if asked;[112] unless he had in mind the exception for therapeutic privilege, believing that information of this nature may be so unsettling for a patient as to be dangerous. This position may have been difficult to support.

Had Harrison J found that Dr Marshman did have a duty to disclose his experience with sympathectomy procedures, his rate of complications and the average rate of complications, the plaintiff would still have needed to establish causation. This may have proven challenging given that Ms Morocz did not ask for such information or otherwise behave in a way that should have induced Dr Marshman to believe that such information would be of significance to her, and the lack of evidence that Marshman was substandard in any way. It is unlikely therefore that this issue, which formed only a minor component of the overall case, would have resulted in a different outcome.

Harrison J's comment notwithstanding, coherence in the judgments regarding disclosure of surgical experience made to date can be discerned when interpreting the tests of materiality with reference to the relative magnitude of risk and costs. This approach provides a clear legal argument for a duty to disclose surgical performance data in particular cases, but not for a general duty at this time. Significantly, this approach does not preclude disclosure of performance data becoming a general duty in the future.

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110 See, eg, Eric C Schneider and Arnold M Epstein, 'Use of Public Performance Reports: A Survey of Patients Undergoing Cardiac Surgery' (1998) 279 *JAMA* 1638; Eric C Schneider and Arnold M Epstein, 'Influence of Cardiac-Surgery Performance Reports on Referral Practices and Access to Care: A Survey of Cardiovascular Specialists' (1996) 335 *New England Journal of Medicine* 251 ('A Survey of Cardiovascular Specialists'); Martin N Marshall et al, 'The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evidence' (2000) 283 *JAMA* 1866.

111 545 NW 2d 495 (Wis, 1996).

112 [2015] NSWSC 325, [192] (Harrison J).

V POLICY CONSIDERATIONS

Given the substantial opposition to public reporting from the medical profession,[113] in considering whether – and to what extent – surgeons should disclose their performance data to patients, it is worth assessing the potential wider consequences. In many cases, evidence of wider implications will contribute to calculations of the cost of disclosure and are therefore relevant considerations.

One of the most frequently raised objections relates to the difficulty in establishing appropriate measures of skill and experience. As Freckelton observed:

> At one level the enhanced duty identified by Gaudron J has much to commend it in terms of supplying to patients information that would make a real difference in their decision as to whether or not to give consent to a surgical or other intervention at the hands of a particular medical practitioner. At another, though, the obligation to provide information by professionals generally about levels of proficiency and experience which could impact upon risks run by consumers will be difficult to translate into practice and may have adverse ramifications for the conduct of medicine by reason of the difficulty in arriving at consistent and accurate measures of performance.[114]

Certainly the crude measure of experience used in *Chappel v Hart* (years in practice) is flawed and is not straightforwardly associated with skill.[115] Qualitative measures of skill, such as peer opinion or patient reviews, have some methodological limitations relating to validity and ease of collection, analysis and dissemination.[116] However, significant progress in improving collection of patient experience data has been made in recent years through initiatives such as the US Agency for Healthcare Research and Quality's program Consumer Assessment of Healthcare Providers and Systems ('CAHPS').[117]

While these have represented valid concerns in the past, they are becoming increasingly irrelevant as data collection through national audits and other mechanisms becomes increasingly sophisticated. The key to producing useful surgical performance data lies in the use of valid and robust methods of data collection, analysis and interpretation. Although statistics are only as good as the dataset that produced them, there are methods for handling missing data and other limitations. Surgical outcomes, such as mortality or complications, are not solely a function of surgical skill, but also reflect patient characteristics and system issues, and many critics worry that it penalises surgeons who take on

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113 Anne Mason and Andrew Street, 'Publishing Outcome Data: Is It an Effective Approach?' (2006) 12 *Journal of Evaluation in Clinical Practice* 37, 43.

114 Freckelton, above n 9, 314–15.

115 Clarke and Oakley, 'Informed Consent', above n 4, 18–19.

116 Note that patients may still consult qualitative measures using tools such as Whitecoat to access consumer reviews of individual practitioners.

117 Agency for Healthcare Research and Quality, *Consumer Assessment of Healthcare Providers and Systems* <https://www.ahrq.gov/cahps/index.html>.

high-risk or complicated cases.[118] However, these factors too can be statistically adjusted for to allow meaningful comparisons to be made.[119] League tables or rankings of surgeons are criticised for being misleading and failing to account for chance variation, as Poloniecki observed: '[e]ven if all surgeons are equally good, about half will have below average results, one will have the worst results, and the worst results will be a long way below average'.[120] It is also important to recognise that differences between individual surgeons might be statistically significant (as a result of very large sample sizes, for example) but not of practical or clinical significance.[121] This means that figures need to be interpreted by those with an understanding of the clinical context, and data needs to be presented in ways that are appropriate.

Arguments predicated on data quality or statistical issues are not arguments against use and disclosure of performance data, but rather arguments for instituting robust data collection and analysis systems. Given that other forces are causing improvements in these areas already, demonstrated by the increased participation in surgical audits in recent years[122] and collaboration between the College and Medibank to produce better datasets,[123] the weight of such objections is rapidly diminishing.

Performance data for individual surgeons has significant practical limitations, and use of such data needs to take these limitations into account and present the data in its appropriate context. One significant limitation is that surgical outcomes are not solely a reflection of the skill of the surgeon. Surgical teams and institutional factors are also associated with patient outcomes,[124] and a surgeon's performance for a procedure may well differ significantly between hospitals. This will be of particular relevance when these additional factors are more influential than the variance between surgeons. Data collection and analysis systems will need to be sensitive to these variables, and disclosure to patients could be made at the level of units or hospitals, rather than individual practitioners, when appropriate.

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118 David M Shahian and Sharon-Lise T Normand, 'What is a Performance Outlier?' (2015) 24 *BMJ Quality & Safety* 95; Schneider and Epstein, 'A Survey of Cardiovascular Specialists', above n 110; Ben Bridgewater et al, 'Has the Publication of Cardiac Surgery Outcome Data Been Associated with Changes in Practice in Northwest England: An Analysis of 25 730 Patients Undergoing CABG Surgery Under 30 Surgeons Over Eight Years' (2007) 93 *Heart* 744.

119 See Paul Aylin, 'Hospital and Clinician Performance Data: What It Can and Cannot Tell Us' in Steve Clarke and Justin Oakley (eds), *Informed Consent and Clinician Accountability: The Ethics of Report Cards on Surgeon Performance* (Cambridge University Press, 2007) 226.

120 Jan Poloniecki, 'Half of All Doctors are Below Average' (1998) 316 *British Medical Journal* 1734, 1734.

121 Ibid.

122 Royal Australasian College of Surgeons, above n 46, 13–14.

123 Royal Australasian College of Surgeons and Medibank, above n 59.

124 Colin B Begg et al, 'Impact of Hospital Volume on Operative Mortality for Major Cancer Surgery' (1998) 280 *JAMA* 1747; Daniel L Davenport et al, 'Risk-Adjusted Morbidity in Teaching Hospitals Correlates with Reported Levels of Communication and Collaboration on Surgical Teams but Not With Scale Measures of Teamwork Climate, Safety Climate, or Working Conditions' (2007) 205 *Journal of the American College of Surgeons* 778; Karen Mazzocco et al, 'Surgical Team Behaviors and Patient Outcomes' (2009) 197 *American Journal of Surgery* 678.

While disclosing performance data in the course of obtaining informed consent for surgical procedures is likely to facilitate patient autonomy, particularly in instances where surgical skill is of heightened importance to the patient, it is unlikely that litigation on the basis of failure to warn will prove an effective driver of quality improvement in health care. However, there is evidence that feedback of performance data to practitioners leads to significant gains in quality improvement.[125] Furthermore, it will be important for medical administrators and regulatory authorities to also make use of performance data for monitoring, performance management and regulatory purposes.[126]

Some commentators have drawn a link between performance data and other information about the practitioner that might affect their ability to undertake their professional duties, including information relating to their health or personal situation. Dolgin suggested that cases like *Johnson v Kokemoor* 'seem to foreshadow a universe within which health care providers could be required to reveal a wide variety of personal information to patients', arguing that the slippery slope would lead to a situation where the trust relationship on which informed consent is founded would be compromised.[127] However, *Johnson v Kokemoor* has not led to extensive changes in the law of informed consent. So far, as Dolgin observed, '[g]enerally, physicians must answer questions about their own limitations but need not volunteer such information'.[128] This is consistent with the Australian situation, and with the division of the test of materiality into objective and subjective limbs.

While there are some superficial similarities between surgical experience and health or personal issues, in that both have the potential to influence surgical outcomes, there are also significant differences. The effect of health or personal issues on outcomes is difficult to quantify, and is therefore perhaps better suited to a threshold approach. That is, when a health (eg, drug dependency) or personal (eg, grief) issue clearly affects a practitioner's performance, intervention from the regulatory authority or personal leave is warranted. In cases such as these, disclosing information in order to facilitate patient autonomy seems to be an inefficient method of achieving optimal results.

One of the most significant objections to disclosure of information about experience and skill is the potential impact on training junior doctors if all patients want the most experienced surgeon.[129] This concern was also noted in *Brus v Australian Capital Territory*:

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125 Constance H Fung et al, 'Systematic Review: The Evidence That Publishing Patient Care Performance Data Improves Quality of Care' (2008) 148 *Annals of Internal Medicine* 111.

126 See, eg, the Medical Board of Australia's intention to amend revalidation processes to include identification of 'at-risk' or poorly performing health practitioners: Medical Board of Australia, 'Medical Board Consults on Revalidation in Australia' (Media Release, 16 August 2016) <http://www.medicalboard.gov.au/News/2016-08-16-revalidation.aspx>.

127 Janet L Dolgin, 'The Legal Development of the Informed Consent Doctrine: Past and Present' (2010) 19 *Cambridge Quarterly of Healthcare Ethics* 97, 103.

128 Ibid 104.

129 Daniel Lee John Bunker, 'Ethical Tensions in Surgery: Who Is Doing My Operation?' (2013) 83 *ANZ Journal of Surgery* 503.

> it would undermine the future provision of health care. Most people would say, as the plaintiff has said in this case that, given the choice between an experienced consultant surgeon and a registrar, who is a qualified medical practitioner undertaking a training program to qualify as a specialist, they would choose the experienced consultant. This would have two effects if such a duty existed. The waiting list for procedures would clearly expand significantly, but more seriously, registrars would not be able to perform the procedures, under close supervision, that they need to qualify as specialists, resulting eventually in a dearth of suitably trained specialists.[130]

Within the public system, there is little opportunity for patients to choose their treating doctor, and may instead be reduced to a choice between having treatment or not having treatment. Further, in many cases, patients are already made aware that junior doctors will form part of their clinical care team. Far from undermining the doctor-patient relationship, this type of honesty may contribute to greater trust as it is indicative of a less paternalistic model of care. Within the private system, patients already have the ability to choose their doctor, within certain constraints, including availability. Evidence from empirical studies suggests that patients value competence, quality of care, experience and communication skills when choosing a doctor.[131] Interestingly, one study found that patients preferred 'word of mouth' recommendations from other patients over information from the internet as a basis for decision-making.[132]

Given these factors, it is difficult to assess the potential impact of increased availability of surgical performance data on patient behaviour. Nevertheless, the potential impact on training of junior doctors remains one of the most important costs that prevent disclosure of performance data becoming a standard part of the duty to warn, beyond particular cases of express interest or anxiety. As hospitals and health care systems adapt to the influence of publicly reported data, and community-specific solutions are developed to mitigate the effect on training, this cost-risk assessment may change.

There is no doubt that doctors are generally opposed to moves to publicise performance data, with representatives citing concerns such as those outlined above in support of their position.[133] However, proponents of public reporting point out that health care has hitherto experienced advantages not afforded to other markets, in that there exists a large discrepancy in access to information between providers and consumers. There is some evidence of a shift in the community on this issue, in line with the move away from paternalistic medicine, with the Consumers Health Forum of Australia arguing that 'in a consumer-centred health system':

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130 [2007] ACTSC 83, [15].

131 Brian H Bornstein, David Marcus and William Cassidy, 'Choosing a Doctor: An Exploratory Study of Factors Influencing Patients' Choice of a Primary Care Doctor' (2000) 6 *Journal of Evaluation in Clinical Practice* 255; Rita Santos, Hugh Gravelle and Carol Propper, 'Does Quality Affect Patients' Choice of Doctor? Evidence from the UK' (Working Paper No 13/306, Centre for Market and Public Organisation, University of Bristol, July 2013); M Smith and K O'Donoghue, 'PA.20 What Do Patients Want in Their Doctor?' (2014) 99 *Archives of Disease in Childhood: Fetal & Neonatal* A23.

132 Smith and O'Donoghue, above n 131.

133 See, for a current example, the Australian Medical Association's opposition to the development of Whitecoat: Alexander, above n 61.

> Consumers should be able to ascertain, for instance, how many times a surgeon has performed a given procedure and the surgeon's success rate. Such data is collected and should be readily available to consumers.[134]

The idea of health as a market like any other was also raised by the former head of the ACCC, Dr Graeme Samuel, who commented:

> Providers used to say to me, 'Health is different, because consumers don't understand, therefore they've got to rely on us to tell them what's best for them' … You have no idea whether the surgeon is a good one or it's Dr Patel, you have no idea whether the anaesthetist might have had incidents in the past, you have no idea whether the hospital has longer length of stay or a propensity for re-infections or complications. This is the sort of information that the average patient ought to have. If there's a medical practitioner who's showing a propensity for complications or failures or readmissions, that ought to be out there. And of course medical providers don't like it. But I can't think of a single business that likes to have its success or the quality of what they're doing exposed, unless they're the best quality and they're proud of it.[135]

This suggests that a degree of medical exceptionalism has previously been prevalent, but that technological and social changes are contributing to a re-evaluation of health as possibly having more commonalities than differences with other markets. This may prove to be the driver that leads to structural, administrative and cultural changes within health care that ultimately allows the risk–costs equation to be redefined.

VI CONCLUSION

While the issue has yet to be squarely addressed in the Australian courts, an analysis of the duty to warn suggests that no objective duty currently exists for surgeons to disclose information about their experience or skill to their patients, although the possibility remains that such a duty may arise in the future. In circumstances where the patient asks for it or a practitioner might reasonably be expected to know that a particular patient would want to know, there is a duty to disclose information about experience or skill. There has been a reluctance of courts so far to extend such a duty, and when a duty has been found to exist in a particular case, they have been careful to preclude a general duty. This is perhaps reflective of uncertainty regarding the societal implications of such a move, and the absence of a clear community expectation. As evidence rapidly accumulates for both these issues, such ambivalence will be unsustainable.

The form information about experience or skill should take remains unresolved in common law, but current trends in data collection, analysis and dissemination within health care suggest that quantitative measures of performance, as opposed to years of experience or qualitative accounts of skill by either peers or consumers, are likely to dominate discussions in the immediate future. Although public reporting of surgical performance data remains highly

134 Consumers Health Forum of Australia, 'Whitecoat a Step Towards a Consumer Friendly Health System' (Media Release, 29 July 2016) <https://chf.org.au/pdfs/chf/20160728-Whitecoat-consumer-health-care-directory-expands.pdf>.

135 Alexander, above n 61.

contentious within the profession, the trend towards greater transparency reflects wider trends, within both medicine and medical law, away from practitioner-centred practice and towards a patient-centred model of health care. The extent to which these developments shape the nature and scope of the duty to warn will need to be determined in future decisions.