Topic Five: Medical Treatment of Disabled Adults

5.1 Determining Competence / Incompetence

- Prima facie, every adult has a right to decide whether or not they will accept medical treatment even if refusal may result in permanent injury or death (*Re MB; Re B*). however, this presumption of competence is rebuttable
- [DP] is likely to meet the definition of disabled under s 3 *GAA* as her/his condition is falls within [intellectual impairment / physical disability / mental disorder / brain injury]

Pursuant to s 36 *GAA*, [DP] will be incapable of giving consent if s/he is -

- (1)(a) over 18; and incapable of giving consent within meaning of (2) (below) to carrying out [**special procedure** /medical or dental treatment]
- (2) cannot consent if [DP] is:
    - (a) incapable of understanding the general nature and effect of the proposed procedure/treatment; or
    - (b) Incapable of indicating whether or not s/he consents/does not consent to the carrying out of the proposed procedure/ treatment

CL test of incompetence

- the CL test of incompetence set out in *Re MB* is largely the same as the statutory test. [DP] will lack capacity if:
    - S/he is unable to comprehend/retain information which is material to the decision, including likely consequences of having/not having treatment
    - S/he is unable to use the information and weigh it as part of the process of arriving at the decision

Linking sentence: given that [DP] is likely to be deemed to be incompetent, it is necessary to determine whether PP jurisdiction will be exercised, and/or whether [agent] has been validly appointed as an agent, and accordingly what powers they can exercise.

Role of the Court - *parens patriae*

- PP is a prerogative of the Crown of those who by virtue of their disability are unable to consent (O'Keefe J in *Northridge*)
- Wide and unlimited: includes power to authorise medical treatment, consent on behalf
- Must exercise PP power very cautiously (O'Keefe J in *Northridge*)
- 'The court is empowered to protect the human dignity and rights of individuals who are disabled in such a way that they cannot protect such dignity and rights for themselves.' (O'Keefe J in *Northridge*)

<u>Paramount consideration (O'Keefe J in *Northridge*)</u>

- Preserve life of patient
- Safeguard, secure or promote life of patient
- Prevent deterioration in the physical/mental health of patient

<u>What PP must NOT be exercised for (O'Keefe J in *Northridge*)</u>

- Exercise of PP is for benefit of patient, not for benefit of others
- Economic efficiency is not sufficient to engage PP power

Australian courts have exercised PP power to authorise

- Life-sustaining treatment (continued care and rehabilitation of patient) (*Northridge*)
- Procedures necessary to harvest bone barrow and collect peripheral blood stem cells for the purpose of donation to another (*Northern Sydney*)

Northridge v Central Sydney Area Health Service (2000)

- Not only should this hospital have a clear rehabilitative policy, but doctors and nurses should enforce this. This premature diagnosis showed that she was quite dismissive of her concerns, acted like they didn't have time, failed to consult relatives, diagnosed vegetative state in just a few days, said treatment would be futile. Serious risk of misdiagnosis was shown in this case

5.2 Powers of Attorney (PoA)

General PoA

- A document that the patient gives someone else the power to act on their behalf for certain purposes
- Ceases to have affect when person loses capacity

Enduring PoA (financial)

- Meaning:
  - Allows a person to make financial and legal decisions for them in the future
- Length of appointment:
  - Beyond the point where the patient / person who gave the power (donor) lacks capacity
  - Different to general PoA in this way
- Commencement:
  - If it doesn't state when power commences it will begin immediately, even if the donor has capacity
- Powers included:
  - Only permits attorney to make financial decisions, can't make lifestyle decisions (such as where someone lives or medical decisions)

Enduring power of attorney (medical treatment)

- Appointed by VCAT as guardians for medical decisions
- Appointed as enduring guardian for these types of healthcare powers
- Deals with **special procedures** and emergency treatment

Guardianship

- Meaning:
  - If an adult becomes incapable of making responsible decisions and no longer able to take care of themselves includes living arrangements; work arrangements, medical treatment, access to people and services
- Enduring power of guardianship
  - Appointed by VCAT or the order

Administrator

- Responsible for managing business, financial and legal decisions

Overview

- *Powers of Attorney Act 2014* (*PoAA*): Only affects **enduring powers of attorney (financial)** and **powers of guardianship**
- Enduring **powers of attorney (medical)** are regulated under the *Medical Treatment Act 1988* (Vic) which will be repealed by the *Medical Treatment Planning and Decisions Act* 2016 (Vic)

Step 1: Creation of PoA

Introduction sentence

[DP] may authorise [agent], an eligible attorney, to do anything on behalf of her/him (s 22(1)). [DP] may confine what is authorised for personal, financial or other matters (s 22(2)). An enduring PoA is not revoked by [DP] becoming a person who does not have decision making capacity after s/he has made the power (s22(3)).

Age and capacity

[DP] [may / may not] create an enduring PoA as s/he [is / is not] over the age of 18 (s 23(1)(a)); and [DP] [has / does not have] decision making capacity* in relation to making the enduring PoA (s 23(1)(b)).

* decision making capacity: exists if [DP] is able to (s 4) –

- (a) **understand the information and the effect** of the decision; and
- (b) retain that information relevant to decision; and
- (c) use / weigh that information in process of making the decision; and
- (d) communicate the decision and [DP]'s views and needs as to the decision in some way
    - Includes: by speech, gestures or other means.

Understanding the effect of an enduring PoA (s 23(2)) includes -

- (a) may place conditions on the power and give instructions about the exercise of the power;
- (b) when the power commences;
- (c) once the power is exercisable, the attorney has the same powers as the principal when the principal has decision making capacity;
- (d) may be revoked at any time when principal has decision making capacity;
- (e) power of attorney continues even if principal loses decision making capacity;
- (f) when principal does not have decision making capacity in relation to revoking power of attorney, the principal is unable to effectively oversee the use of the power.

Step 2: is [attorney] eligible to be appointed as an attorney?

For all kinds of attorneys:

[Attorney] [is / is not] eligible to be appointed as [DP]'s attorney because [agent] [is / is not] over the age of 18 (s 28(1)(a)), [is / is not] an insolvent under administration (s 28(1)(b)).

For **financial attorneys**:

[Attorney] [has / has not] been convicted or found guilty of an offence involving dishonesty (insert offence if relevant) (s 28(1)(c)).

If [attorney] has committed such an offence: [s/he] [has / has not] disclosed the conviction / finding of guilt to [DP] and the disclose [has / has not] been recording in the enduring PoA.

<u>For all kinds of attorneys:</u>

[Attorney] [is / is not] a care worker, a health provider or an accommodation provider for [DP] (s 28(1)(d)).

Care worker:

- A person who performs services for the care of the individual and receives remuneration for those services from any source
- Does not include:
    - (a) A person who receives a carer payment or other benefit from the Commonwealth or a State or a Territory of the Commonwealth for providing home care for the individual; or
    - (b) A person who is a *health provider
        - *Health provider: A person who provides health care in the practice of a profession or in the ordinary course of business

Accommodation provider:

- A person who is directly or indirectly responsible for or involved in the provision of accommodation to the individual in a professional or administrative capacity

<u>Enduring PoA cannot:</u>

- Delegate a power (s 25):
    - If attorney is no longer able to carry out role, an alternate attorney has to be appointed (see s 31 below)
- Make or revoke a will for the principal (s 26):
    - Vote on their behalf, consent to a divorce, make or give effect to the care and well-being of a child of the principal; consent or discharge a parenting order, manage the estate of the principal or their death
- Appoint more than one attorney (s 30):
- Appoint an alternative attorney (s 31)

Step 3: Supportive attorney (only do Step 3 if [attorney] appoints a supportive attorney)

- [Attorney] may appoint an eligible person to support [her/him] in making and giving effect to decisions (s 85(1)). This will be in relation to a supported decision (s 85(2)), being a decision about a matter that the supportive attorney is authorised to support [DP] in making.
- [Attorney] is not able to authorised [another person] to support [attorney] in conducting any illegal activity (s 85(3)(a)), or to coerce, intimate or in any other way unduly influence the person into a particular course of action (s 85(3)(b)).

5.4 Advance Care Directives (ACD)

Medical Treatment and Planning and Decisions Act 2016 **(Vic)**

- Any medical refusal certificates before 12 March 2018 will remain in force under the previous regime. S 101 repeals the *Medical Treatment Act* 1988 (Vic)

'Medical treatment decision' (s 3)

- Means a decision to consent to or refuse the commencement or continuation of medical treatment or a medical **research** procedure

Principles (s 7)

- (1) A person exercising a power or performing a function or duty under this Act must have regard to the following principles:
  - (a)(i) Right to make informed decisions about the person's medical treatment or medical **research** procedures
  - (a)(ii) given, in a sensitively communicated and clear and open manner
  - (c) be shown respect for the person's culture, beliefs, values and personal characteristics
  - (d) A person's preferences, values and personal and social wellbeing should direct decisions about the person's medical treatment or medical **research** procedures that may be administered to the person
- Nb: Act provides statements of principles which are very much consistent with AMA Code of Ethics

Content of advance directive (s 6)

- (2) An ACD may contain either or both of the following -
  - (a) **An instructional directive**
  - (b) **A values directive**

Instructional directive

- (a) is an express statement in an ACD of a person's medical treatment decision
- (b) takes effect as if the person who gave it has consented to, or refused the commencement or continuation of, medical treatment, as the case may be.
- Examples:
  - A statement that a person consents to a heart bypass operation in specified circumstances.
  - A statement that a person refuses cardiopulmonary resuscitation.

Values directive

- A statement in an ACD of a person's preferences and values as the basis on which the person would like any medical treatment decisions to be made on behalf of the person, including, but not limited to, a statement of medical treatment outcomes that the person regards as acceptable.
- Does not have to be specific
- Can be more than one form of medical treatment, or a course of medical treatment
- Examples:
  - 'If I am unable to recognise my family and friends, and cannot communicate, I do not want any medical treatment to prolong my life.'
  - 'If a time comes when I cannot make decisions about my medical treatment, I would like to receive any life prolonging medical treatments that are beneficial. This includes receiving a medical **research** procedure to see if the procedure has any benefit for me.'

An instructional directive will be construed as a values directive if (s 12(3)) **-**

- (a) Does not expressly identify any statement, or
- (b) It is unclear
- (c) Is a **special medical procedure** about palliative care or an advance directive document of another State or Territory

Both types can be given (s 6(3)) –

For (a)
- (i) Medical treatment or a medical **research** procedure to be provided in a particular instance; or
- (ii) A course of medical treatment or medical **research** procedures to be provided over a period of time

About (b)
- (i) one or more particular forms of medical treatment or medical **research** procedures; or
- (ii) generally about all medical treatment or medical **research** procedures; and

So as to apply (c)
- (i) in all circumstances; or
- (ii) only in specified circumstances; or
- (iii) in all circumstances except in specified circumstances.

Who may give an ACD? (s 13)
- Any person (including a child) may give an ACD if—
    - (a) the person—
        - (i) has decision-making capacity (defined in s 4 below) in relation to each statement in the directive; and
        - (ii) understands the nature and effect of each statement in the directive; and
    - (b) the requirements of this Part are complied with.

Decision-making capacity (s 4)
- (1) A person has decision-making capacity if the person is able to -
    - (a) understand the information relevant to the decision and the effect of the decision;
    - (b) retain that information to the extent necessary to make the decision;
    - (c) use or weigh that information as part of the process of making the decision;
    - (d) communicate the decision and the person's views and needs as to the decision in some way, including by speech, gestures or other means.
- (2) For the purposes of subsection (1), an adult is presumed to have decision-making capacity unless there is evidence to the contrary.
- A person is taken to understand an explanation of information appropriate to the person's circumstances, whether using modified language, visual aids or any other means (s 4(3))

Decision-making capacity can be (s 4 (4))
- (a) Making some decisions and not others
- (b) Can be temporary
- (c) It is not based on the person's appearance or in the opinion of others is unwise

Topic Six: Liability for Medical Negligence

- Nb: all provisions refer to the *Wrongs Act* unless stated otherwise

6.1 Duty of Care

A) Direct relationship

- The doctor/patient DOC is well-settled law, premised in the proximity of the relationship (*Donoghue v Stevenson*)
- Therefore, it is clear that [doctor] owes [patient] a DOC. This is a single comprehensive duty (*Rogers v Whitaker*), covering all the ways in which a health professional is called upon to exercise that skill and judgement.

Therefore, the scope covers:

- [Doctor] [examining/diagnosing/treating/providing information or advice] to [patient] (*Rogers v Whitaker*)
- [Doctor] deciding which risks to voluntarily warn a patient and the terms in which such warning, if nay, should be given (*Sidaway v Bethlem*)

When DOC commences:

- Treatment need not have commenced for DOC to be imposed (*Albrighton*)
    - In *Albrighton*, it was clear that a traction was required, or the patient could become paraplegic. Neurologist asked to look at traction but had not done so. Court found that he still owed a DOC despite not having seen the patient yet.

B) No direct relationship (non-exhaustive list)

- Owing a duty outside a therapeutic relationship, to people who are not even their patient

<u>Emergency</u>

- Do not need a pre-existing / direct relationship between parties if there is an emergency (*Lowns v Woods*)
- *Lowns v Woods*:
    - 14 year old's 10 year old brother was having an epileptic fit. She got doctor, who did not attend. P suffered severe brain damage that could have been avoided if doctor treated him properly. Doctor still owed a DOC. There was sufficient proximity between the parties to establish a duty, despite their lack of professional association.
- Nb: *Lowns* has been criticized as it was highly influenced by NSW legislation, which provided that failure to attend in an emergency situation constitutes professional misconduct

<u>No health care qualifications</u>

- People without health-care qualifications can still have a DOC to patients (*Alexander v Heise*)
- *Alexander v Heise*:
    - Facts: Husband had severe headaches, told receptionist his symptoms. Appointment made for 11th March, he collapsed into unconsciousness on 10th March (died later).
    - Held (Full SC of NSW): Both the doctor and the receptionist owed a duty to the prospective patient, but because they decided that the duty wasn't breached, the precise content and scope of the duty was not required to be determined

Third parties

- The doctor owes a concurrent DOC in tort and contract to that third party (*Thomsen v Davison*)
- *Thomsen v Davison*:
    - Facts: D was an army medical officer. D examined P via blood and urine tests. Tests revealed likely kidney disease. D did not follow up on test or advise P what it revealed.
    - Held: D did not only have a duty to the company, but to conduct the check-up competently. D should have reasonably foreseen that it may have caused harm to P.

Consultations and second opinions

- Contractual relationship is between doctors, but still the second doctor owes patient a DOC (*Albrighton*)
- *Albrighton* (NSW CoA): Although neurosurgeon was not directly responsible for the treatment of the patient, he knew the possible danger to the patient's spinal cord. Ostensibly P became his patient, and he owed a DOC.

Pathology test

- Pathologist has to take reasonable steps to ensure that results from blood and urine tests get communicated to referring doctor (*Thomsen v Davison*)
- There is no distinction that is drawn between duty of a private pathologist or a pathologist employed by a public body (*Thomsen v Davison*)

C) Particular duty categories

1) Unborn children

- DOC extends to a fetus, who is not a person at law (*Watt; X and Y*).
- D does not need 'to identify the person ultimately injured', it is sufficient that s/he 'can identify a class of persons apt to be injured and that P is in the event of that class' (Mahoney JA in *X and Y*).
- *Watt v Rama*; *V v Islington*:
    - Facts: Pregnant woman involved in car accident. When child was born it was damaged. Child sued driver.
    - Held: Pregnancy is RF (lots of pregnant women in community). Drivers not only have a duty not to cause damage to other people, but also to a potential child
- *X and Y*:
    - Facts: X was pregnant, but she didn't know she was suffering from syphilis. She consulted two doctors, one failed to screen her for syphilis. X gave birth to Y who had deformities
    - Held: Doctor not only owed duty to X (his patient), but also to Y as a fetus. P doesn't have to be born at time of doctor's carelessness, whether or not a DOC arises depends on whether or not there is a relevant relationship between health professional and class of persons

2) Wrongful Birth: Topic 7; 3) Wrongful Life: Topic 7

4) Nervous shock

- Concept of 'shock' refers to something sudden or disturbing to occasion lasting depression or loss of composure (*Wicks*)
- Can be ongoing shock (*Wicks*)
    - In *Wicks*, PMH clearly emanated from this type of shock, it wasn't just confined to the P's first perception of the scene but also ongoing shock

Types of mental harm (s 67):

- Consequential Mental Harm (CMH): Mental harm that is a consequence of any other injury of any other kind
- Pure Mental Harm (PMH): Mental harm other than CMH, will be pure because it is not a consequence of another injury (personal or bodily)
- Mere grievance is not enough

INDIRECT MENTAL HARM (s 73):

- (1) Where PMH results – in whole or in part – due to another person being killed, injured or put in danger by D's negligence
- (2) P is not entitled to recover damages for PMH unless –
    - (a) P witnessed, at the scene, the victim being killed, injured or put in danger; or
        - Removes people who hear about it later
    - (b) P is or was in a close relationship with the victim
- (3) No damages to be awarded if the victim would be unable to recover damages from the D

Witness at the scene:

- *Wicks v State Rail Authority of NSW*:
    - Facts: Train crashed due to State Rail's negligence. 7/50 passengers died and lots injured. Policemen attempted to rescue survivors. Policemen suffered PTSD.
    - Held (HC): Being killed, injured or put in peril do not necessarily occupy a time measured in minutes. In some cases, death, injury or being put in peril takes place over an extended period

Close relationship:

- *Gifford*: employer owed a DOC to children of a man crushed in a 'horrific' fork life accident (caused by employer's negligence), despite children not witnessing the event or seeing his body. It is RF that children would suffer psychiatric injury from death of their parent.
    - McHugh J: It is the closeness and affection of a relationship – rather than the legal status of the relationship – that is relevant in determining a DOC (follows on from 'neighbourhood' principle encapsulated by Lord Atkin in *Donoghue v Stevenson*) (*Gifford*)
    - Gummow and Kirby: liability in negligence for 'nervous shock' does not depend upon satisfaction of an absolute requirement that a plaintiff 'directly perceive' the relevant distressing incident or its 'immediate aftermath' (*Gifford*)

PURE MENTAL HARM:

- S 72(1): foreseeability
    - [D] does not owe a duty to [P] to take care not to cause the P PMH unless [D] foresaw or ought to have foreseen that a person of normal fortitude might, **in the circumstances of the case** (see below), suffer a recognised psychiatric illness if reasonable care to [insert negligent action] were not taken
- S 72(3): normal fortitude
    - This section does not affect the duty of care of [D] to [P] if [D] knows, or ought to know, that [P] is a person of less than normal fortitude
- S 72(2): The **circumstances of the case** include the following –
    - (a) whether or not the mental harm was suffered as a result of a sudden shock
    - (b) whether [P] witnessed, at the scene, a person being killed, injured or put in danger
        - Similar to *Wicks*
    - (c) the nature of the relationship between P and any person killed, injured or put in danger
        - Similar to *Gifford*

    - (d) whether or not there was a pre-existing relationship between P and D
- S 71: Except as provided by this Part, this Part is not intended to affect the common law

SALIENT FEATURES

- As this part is not intended to affect the CL (s 71), in other areas, including prevention of harm not directly caused by the D and instances of non-physical loss, can use CL salient features to establish RF and DOC (*Sullivan*)
- [P] would argue that it was RF, in the sense that it was not far-fetched or fanciful (*Sullivan*) that a failure to exercise reasonable care could result in harm to the P or a class of persons to which s/he belongs (*Chapman v Hearse; Donoghue v Stevenson*)

Assumption of responsibility / relationship between parties:

- *Tame*: D gave assurances to P that their son would be ok, which gave rise to a DOC. This is a 'triangular relationship' that unified the parties
- *Gifford*: relationship between victim and Ps was close and loving relationship pointed heavily toward foreseeability and DOC
- *McDonald*: close relationship pointed towards DOC being imposed for doctor not performing sterilisation procedure correctly

No indeterminate liability (i.e. if liability cannot be realistically calculated):

- *Tame*: the assumption of responsibility and pre-existing relationship demarcated to whom duty was owed
- *Gifford*: limited by nature of the relationship between the P and the victim

Vulnerability:

- *Tame*: P were vulnerable to the risk of harm the D exposed them to (and their son)
- *Gifford*: Ps had no way of protecting themselves

Control:

- *Tame*: D controlled the circumstances giving rise to the risk to the P (and their son)
    - This is a constant theme in employer situations
- *Gifford*: D controlled the circumstances giving rise to the risk, i.e. area the father worked was controlled by D

Interference with legitimate business activity:

- *Tame*: not legitimate to expose employees to risk of harm. D owed a paralleled duty to P's son.

No conflict of duties:

- *Tame*: the duty to the P would simply be co-extensive to the settled duty to the employee
- *Gifford*: it is not legitimate to expose employees to risk of harm. Didn't interfere with any free carrying on of a business, it is a paralleled / co-extensive duty
- *McDonald*: no conflict in duties with performing sterilisation procedure correctly

6.3 Damage

a) Damage recognised by law

Loss of chance / opportunity

- [Patient] may argue that because of [doctor]'s [breach e.g. failure to warn], s/he lost the opportunity to [insert facts, e.g. get a more experienced doctor]
- However, loss of chance is generally not establish as law as a recognizable and compensable form of harm (*Tabet*).
- As per Kiefel J in *Tabet*, there is an all or nothing rule. Therefore, if [patient] can prove on the BOP more than a 50% probability of a better outcome, causation will be made out, D will be taken to have caused the injury, and [patient] prima facie will be compensation for 100% of her/his loss

If doctor doesn't warn of their limited experience:

- [Patient] can argue that Gaudron J's decision in *Chappel* supports recognition of a duty on the part of a surgeon to advisee the patient of their limited experience/that there are more experienced surgeons practising in the field

Chappel v Hart

- P not warned of inherent risk of infection, which could damage her nerves and voice. P suffered infection. If P had been informed of the risk, she would have deferred the procedure and had it performed by a more experienced surgeon.

Tabet v Gett [2010] HCA:

- Facts: T had symptoms of brain tumour, paediatrician said was just chicken pox. Waited a few days to have CT scan. When this happened, showed tumour. T left with brain damage. Argument: on the first day that she had presented, a CT scan should have been ordered If CT scan was performed day before, T would have had a 40% chance of a better outcome
- Held: causation not made out as loss of chance was under 50%

b) Causation

- As per *Chappel*, it must be shown on the BOP (s 52) that [patient] would not have had [operation] if warned of the risk that eventuated
- This is unlikely to be made out if [patient] would have proceeded with [procedure] anyway (as occurred in *Rosenberg*)

Section 51(1) Causation comprises two limbs

S 51(1)(a) IN FACT

The negligence was a necessary condition of the occurrence of the harm (factual causation):

- Reflective of the CL 'but for' test (seen in *March*)
- This is a question of common sense (*Chappel v Hart*)

Subject and objective tests *(Chappel v Hart*):

- Subjective test: if [doctor] had given the information, [patient] would not have agreed to the procedure and so would not have suffered the injury or loss
    - *Chappel*: patient would not have proceeded if warned
    - *Rosenberg*: patient would have proceeded even if warned

- Objective test: what P would have done if warned of the risk - consider what the reasonable person in P's position would have done

Other things to consider

- If damage affects patient's job (*Chappel*)
    - *Chappel*: P was a principle education officer, needed her voice to do her job. After risk eventuated (damage to her voice), she was forced to retire. Pointed towards breach.
- Possibility of obtaining a more experienced doctor / surgeon (*Chappel*)
    - *Chappel*:
        - P said if she knew of risk she would have sought out the most experienced surgeon to do her ear nose throat surgery. It wasn't a physical injury, it was loss of a chance to have surgery performed by someone else at some other time.
        - Dr C argued: no cause or connection between failure to warn of risks and damage suffered, argued this infection was a 'random event' that could have occurred no matter who surgery was performed by
        - Gaudron: doctor may owe a DOC to a patient to advise of their experience. Although perforation and infection are inherent, the risk of injury being the same no matter what surgery, that's not to say the likelihood of the risk occurring was the same. It wasn't a physical injury, it was loss of a chance to have surgery performed by someone else at some other time.

'Probable' cause

- *Sydney South West v Stamoulis*:
    - Negligent failure to perform an ultrasound, which would have detected a tumour, lead to diagnosis, person would have gotten treated. Instead, there was a 10 month delay, resulting in the P's breast cancer spreading – increasing risk to 10%. P still had to prove causation.
    - Later, the prospect of it spreading was about 62%. Based on common sense, can convert a strong possibility into a probability.
- *Amaca v Ellis*:
    - Facts: man exposed to asbestos from two employers. One employer was 1975-78, other employer was 1990-2002. Man smoked 15-20 cigarettes a day for 26 years. He died of lung cancer. Evidence indicated that relevant risk of lung cancer due to smoking was much greater than the risk due to exposure of asbestos
    - Held: exposure to asbestos may have been a cause, but it was not a probable cause.
- *Amaca v Booth*:
    - Facts: Booth was a break mechanic (exposed to asbestos dust for 30 years). He also did home renovations (exposed to asbestos for 9 years By Amica – D1). At age 71, he developed lung cancer. For the subsequent 21 years of his working life, he was exposed to asbestos by D2. Joint venture by two companies (James Hardie involved in both companies). JH argued that working for these companies led to 70-75%
    - Held: both D companies were liable, breach in failing to warn P of risk of harm. Instead of a single fibre theory, look at how different exposures cumulatively bring about cancer (moved away from UK test of material contribution to risk).
- *Chappel*:
    - Dr C argued that the results occurred in every 30 or 40 operations, it's a rare infection. So rare it had not occurred in 100-150 operations performed in experts.
    - Court still found that Dr C breached DOC
- *Hotson v East Area* (UK case):

- Boy fell from tree, fractured his hip. Hospital failed to diagnose fracture for 5 days. As a result, boy got arthritis. 75% chance that boy would have developed this arthritis in any event. HoL: P unsuccessful, if P is not able to prove on BOP that the delay contributed to damage suffered, because it could have happened in any event

If there is more than one risk but only one eventuates:

- *Wallace v Kam*:
  - Facts: W underwent surgery to alleviate pain in his lumber spine. Procedure had inherent risks. Risk 1: Temporary local damage to nerves in his thighs – numb as a result of lying down flat. Risk 2: 1 in 20 chance of permanent catastrophic paralysis from damage to the spinal nerves. Dr K was a neuro surgeon, performed procedure, it was unsuccessful. W's condition didn't improve. Risk 1 materialised, Risk 2 did not.
  - Held: W would have gone ahead even if he was warned of Risk 1. It was only if he were warned of Risk 2 that he may not have proceeded with the operation. The risk that actually happened was Risk 1. Doctor's duty was to warn him about both of those risks because both risks are material. But here, no cause in law, just a cause in fact.
  - In novel cases, like this one, need to be explicit regarding the policy considerations. In this case policy:
    - In favour of liability: warning reinforces the content of the doctor's DOC
    - Against liability: patient's right to an informed choice. A P should not be compensated for the materialisation of risks they would have been prepared to accept.

S 51(1)(b) SCOPE OF LIABILITY (causation in law)

- It must be appropriate for the scope of the negligent person's liability to extend to the harm so caused (s 51(1)(b))
- S 51(4): for the purpose of determining the scope of liability, the court is to consider (amongst other relevant things) whether or not and why responsibility for the harm should be imposed on the negligent party
- *Novus actus interveniens* – where there are a number of factual causes operating on the P in succession, which is legally relevant for the purpose of attributing legal liability
- Could also bring up policy arguments for/against finding of causative legal responsibility
- If failure to warn case:
  - If it is relevant to determine what the injured person would have done if the negligent person had not been negligent, s 51(3) requires that the matter is to be determined subjectively in light of all relevant circumstances

Things to consider:

- Policy factors in determining whether D ought to be liable to pay damages for loss
- The CL applied the test of reasonable foreseeability
- I.e. whether the kind of damage that arose would be regarded by a reasonable person in the position of [defendant] as a real risk, as opposed to being far fetched or fanciful