Chinese Whispers: Judicial Narratives and the Regulation of Clinical Medicine

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This article explores the process by which a set of medical “facts” is often distorted as it progresses through the legal system to be finally incorporated in a “judicial narrative”. The term “judicial narrative” relates to the way in which facts are set out in the published judgment of a court. The similarities and differences between such narratives and literary, medical and historical narratives are examined. It is contended that one of the primary purposes of judicial narratives in medical cases is to form part of a system of professional regulation. This creates a burden on the regulator, particularly at an appellate level, to make such pronouncements comprehensible and relevant to the target audience. However, because of the unchecked distortion of language, facts and structure, the final judicial narrative in many medical cases, including the two cases chosen as examples, is often unintelligible to health professionals. Consequently, such judicial narratives have a tendency to fail to reach their most appropriate audience, namely those health professionals obliged to use them to improve safety for their patients.

Introduction

“This is Frederica’s first legal narrative. It is an official tale, told to a partial, official listener. Frederica selected its narrative elements; [her lawyer] sorted, assessed, rearranged and added to them. It is only the beginning. There will be more. And more, and more.”1

“The doctor regarded him sternly over his spectacles with one eye, as though to say, ‘Prisoner at the bar, if you will not keep to the questions put to you, I shall be obliged to have you removed from the court.’ ”2

In the playground game “Chinese whispers”, a child whispers a story in another’s ear. The tale is similarly passed on, becoming increasingly distorted until the facts of the initial narrative are almost unrecognisable. If that first message contained an instruction, the action it eventually produces will inevitably be inappropriate.

When a client first presents a set of facts to a solicitor, a similar process is commenced. If the legal matter is taken on appeal, the final “judicial narrative”, the conclusive, published, legal “telling” of the story, may as a result be

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3 The term “judicial narrative” when used in this article refers to the account of the facts of a case constructed by a judge in his or her judgment. The term “medical narrative” refers to the account of facts relating to a particular patient as constructed by doctors in managing and treating the patient’s medical problem.
significantly altered from the original story communicated by the client. This is in large part due to the process of weighing competing narratives inherent in the adversarial system of law. This situation is compounded and acquires added significance when medical facts undergo this process. The medical system itself progressively reorganises a patient's tale of illness in order to approximate the "truth" by weighing it against already published "competing" diagnostic and therapeutic narratives of the course of different diseases. We emphasise, however, that the explicit purpose of each judicial narrative in relation to medical trials is not only to resolve a dispute in a particular case, but also to form the basis, through the doctrine of stare decisis, of a system of professional regulation. Using as examples the New Zealand case of \textit{R v Yogasakaran}\textsuperscript{6} and the Australian decision in \textit{Rogers v Whitaker},\textsuperscript{7} both of which initiated major structural changes in the practice of medicine in their respective jurisdictions, we argue that the clinical facts in medical cases are usually so recast and distorted by the time of their incorporation into a published judicial narrative as to be relevant only to an audience of lawyers and not to the most appropriate audience, namely those health professionals obliged to use the lessons resulting from such legal judgments to improve safety for their patients.

This article is divided into four sections. The first section briefly looks at the concepts of "truth" and "regulation" in judicial narratives concerning medical cases. The second section compares judicial, literary and medical narratives. The third section draws upon critiques of the use of narrative in historical writing to further explain the importance of the process of distortion in judicial narratives of medical cases. The final section examines \textit{R v Yogasakaran} and \textit{Rogers v Whitaker} as examples of the current deficiencies of judicial narrative as a form of regulation of the medical system.

### Judicial narratives and the concepts of truth and regulation

In \textit{R v Beharrelli},\textsuperscript{8} L'Heureux-Dubé J stated that the "principal aim of our adversarial trial process is the search for the truth".\textsuperscript{9} While this assertion may seem questionable in an age where law is increasingly viewed as solely involving the best resolution of a dispute, it has traditionally been assumed by lawyers that the "truth" behind a particular legal problem may ultimately be found by a judge or jury through a process of weighing competing "narratives".

The term "narrative" is taken here to refer to a connected account of events which produces a story. Narratives in legal trials derive, in the main, from witnesses. In a trial concerning medical negligence, for example, witnesses will often have rehearsed their story with themselves, with family and friends, with police, and with other professionals. Their tale will probably have been refashioned later when told to solicitors, "brushed up" in conference prior to trial, led out in chief, then recast in cross-examination.

The sequence and version of events finally accepted at trial will be summarised by the presiding judge and recounted in a judgment delivered or "handed down" in an open court ritual to his or her associate. This may itself be retold in a published judgment by an appellate court where the facts are "sanitised" for relevance to stated questions of law. The abbreviated accepted narrative then becomes the conclusive "telling" of the story, immortalised as part of the "common law".\textsuperscript{10}

Unquestioning acceptance of the assertion that some form of "truth" can ultimately be reached through the adversarial process of weighing

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\textsuperscript{4} When judges apply the principle of stare decisis, they are simply applying binding legal rules set out in a previous judgment on a similar issue. Sometimes this procedure is referred to as applying the doctrine of precedent. See, eg, G Morris, C Cook, R Creyke and R Geddes, \textit{Laying Down the Law} (Butterworths, Sydney, 1992), p 31ff.

\textsuperscript{5} This is true whether the "patient" or "professional practice" standard is used to determine breach of duty of care. See \textit{Sidaway v Governors of Bethlem Royal Hospital} [1985] AC 871 and \textit{Rogers v Whitaker} (1992) 175 CLR 479.

\textsuperscript{6} [1990] 1 NZLR 399.

\textsuperscript{7} (1992) 175 CLR 479.

\textsuperscript{8} (1995) 130 DLR (4th) 422 (SCC).

\textsuperscript{9} Ibid at 450.

\textsuperscript{10} The term "common law" may be used in a number of quite different ways. We are using it here to refer to law created by the courts as opposed to law enacted by Parliament. For other uses of the term, see G Nettheim, \textit{Understanding Law} (Butterworths, Sydney, 1988), p 18ff.
competing narratives downplays the manifest regulatory function of judge-made law. James Boyd White writes that "[e]very utterance has meanings beyond the purely intellectual – meanings that are, just to begin the possibilities, political, ethical, cultural, aesthetic, social and psychological in character". Judicial narratives, particularly at the appellate level, provide not only resolutions of individual disputes, but have far wider implications for those obliged to follow judge-made law. The "common law" derives its social impetus from a knowledge that these published judicial narratives become a guide to future conduct in the community. The ratio decidendi of each case gives an indication of how a legal problem arising from similar facts will be decided in the future. In trials dealing with facts arising from a medical context, the final judicial narrative is thus taken not only to represent the "truth", but to be an instrument for regulating future behaviour by health professionals.

Despite the increasing regulatory importance of judicial narratives, we suspect that few doctors currently read the judgment of a medical trial as recorded in the relevant law reports. They may read a paraphrase of it in a medical journal or newspaper or be given an abbreviated account by a colleague. This lack of interest in the original judicial narrative does not arise from disrespect or lack of availability, although the latter may be of some relevance. It arises primarily from the fact that after so much legal retelling, reinterpretation and translation, not only is legal language a barrier, but the clinical context has been so abbreviated that the regulatory message is unintelligible to those doctors whose conduct it is intended to influence.

Judicial, literary and medical narratives

Narrative theory has become a growing part of legal scholarship in recent years, primarily as a method of exposing the way in which the law excludes the stories of members of minority groups and women. This literature, however, is apt to leave unexplored the fact that the adversarial trial process has always been pervaded by competing narratives. Brooks writes:

"Narrative is indeed omnipresent in the law, something that has no doubt always been recognised but has rarely been attended to in an analytic manner." In fact, while it appears a truism to state that the trial process is all about the presentation of differing narratives, there has been a resistance to the idea of interpreting the law as involving storytelling to an audience perhaps because stories are seen as "beyond the realm of reason", whereas legal writing has traditionally been viewed as logical, objective and concerned with relating the "truth". Thus, it is said, it pays to be "cautious in applying the rhetoric of literature" to judicial writing.

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12 This literally means "reason for deciding" and it is only the ratio of a judgment which can be "binding" upon an inferior court in the judicial hierarchy where such a court is hearing a case possessing similar, relevant facts.
13 As well as the purposes of providing truth and regulation, judicial narratives may also possess a "compensatory" function. A recent trend in medical negligence cases is what may be perceived to be an increasing tendency of judges to compensate unfortunate plaintiffs possibly at the expense of these "truth declaring" or "regulatory" functions.

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18 P N Leval, "Judicial Opinions as Literature", in Brooks and Gewirtz, op cit n 15, p 207.
Such a view fails to take adequately into account other important functions of judicial narratives. Such narratives are also devices by which the life of their author is made into a unity, is made to work towards some perceived goal. A judge, for example, may view his or her judgments as reflecting and promoting a unique "style" or view of "compassion" or "justice".

Many have called, in recent times, for changes in undergraduate and legal education which would make it easier to acknowledge the emotional and subjective factors in judicial narratives. Literary narrative is thus said to make "its special claims upon us precisely because it nourishes the kinds of human understanding not achievable through reason alone but involving intuition and emotion as well. If law engages non-rational elements and requires the most comprehensive kinds of understanding, literature can play an important role in a lawyer’s development."¹⁹

This point may be illustrated by comparing more closely judicial, literary and medical narratives.

**Differences**

**Purpose**

The purpose of literary narratives is often viewed as being merely to entertain or to astonish or to reflect the vagaries of life. However, there is an increasing movement to see literary narratives as having a regulatory, moral function.²⁰ Thus the claim that the best literary narratives must have an ethical purpose, that is, an ability to change lives for the better, may be mirrored in the realisation that judicial and medical narratives have a regulatory purpose in aiming to make patients' lives safer.

The dual purposes of truth and regulation in relation to judicial narratives have already been mentioned. Cover may perhaps have overstated the case when he referred to the "violence" of the text of judicial opinions,²¹ but it is undeniable that the words of a judgment have a force which distinguishes them from literary or medical narratives. Judgments have serious consequences for the parties involved in the trial process and often for many third parties as well. Judicial narratives can be enforced by the executive power of the state and disobedience may be punished by deprivation of liberty or money. These consequences are another reason for judicial narratives to be intelligible to the audience whose conduct is regulated by them.

Medical narratives – as recorded in ward or practice notes, or recounted verbally in shift handover to consultant specialists or, less often, in morbidity and mortality meetings, grand rounds or medical journal case notes – have a primary purpose of reaching the "truth" about a patient's problem. However, they also have the purpose of educating doctors, increasing the "pool" of clinical knowledge, improving quality of outcome for subsequent patients and "defending" or "justifying" clinical decisions. "Truth" is obtained in this setting by comparing an accurate clinical history along with the results of series of objective tests, such as physical examination and a variety of biochemical, pathological, radiological, surgical and serological investigations, with a "competing" range of published narratives of possible disease processes. This process has its own problems as regards serial distortion of the original narrative. Hunter writes:

"The case history is not the patient's story, nor is it meant to be. It subordinates the patient's experience to the medical reconstruction of events, rigorously ignoring the fear and bewilderment, the loss of control and the suffering that may attend the experience of illness. The patient is flattened, the narrator is almost effaced; the narrative as a whole is relentlessly passive. This is not cruelty, but what the patient has come for: an objective gaze that..."

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can establish with relative certainty what the
matter is." 22

**Audience**

The actual, if not the intended, audience for judicial narratives is a very small one in comparison to the audience for literary narratives. Levinson points out that while courts write to audiences, they may only be writing to intended, hoped-for audiences, given that very few academic lawyers, let alone practising lawyers, read opinions of any court apart from that of the highest appeal court. 23 Yet in medical cases one undoubted audience consists of doctors, particularly where a new standard of care is being established or an existing standard confirmed by the court.

The audience for a medical narrative has traditionally been other doctors and health professionals. Doctors have traditionally not written clinical narratives with an audience of lawyers in mind. This is changing, however, through the perceived increasing threat of medical litigation and is one reason why quality assurance mechanisms are eschewing medical records for contemporaneously administered questionnaires in genuine attempts to investigate adverse patient outcomes. 24

**Style**

The narrative form used by lawyers and doctors is generally of a more grammatically restricted variety than that used, for example, in fiction. The third person is generally used to omit any sense of a narrator. 25 Genette notes that in such narrative discourse, "[t]he events are chronologically recorded as they appear on the horizon of the story. No one speaks. The events seem to tell themselves." 26

There is also a specific format for judicial narratives. In a medical negligence case, a summary of the facts and the legal issues raised by them is generally set out first, followed by a summary of the relevant common law principles derived from the ratio decidendi of judicial narratives with similar relevant facts. A discussion of the law then ensues, followed by its application to the present facts and concluding with the final order.

Literary narratives generally follow established rules pertaining to plot and character and so on, 27 but much more freedom in structure is available to the author. This freedom is likely to be restricted proportionately with the size of the audience contemplated. Publishers and editors are a strong regulatory influence here.

Medical narratives are carefully moulded into the model of the objective "case" history, with every fact being mentioned, weighed and ordered for its relevance to the diagnostic or therapeutic problem at hand. Deviations from this "style" may result in lack of professional advancement (specialist exams are focused on its development), poor professional relations with colleagues and misunderstandings deleterious to the patient.

**Similarities**

In Tolstoy's *The Death of Ivan Ilyich*, the similarities between the way in which facts are treated in medical and legal narratives is saliently described. Tolstoy's magistrate has perfected in his daily work a technique of "eliminating all considerations irrelevant to the legal aspect of the case, and reducing even the most complicated case to a form in which the bare essentials could be presented on paper, with his own personal opinion completely excluded and, what was of paramount importance, observing all the prescribed formalities." 28

Now, in his illness, "[t]he entire procedure was just the same as in the Law Courts. The airs that he put on in court for the benefit of the prisoner at the bar, the doctor now put on for him." 29

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25 "Narrative in the strictest sense is distinguished by the exclusive use of the third person and of such forms as the preterite and the pluperfect": G Genette, "Boundaries of Narrative" (1976) 8 (1) *New Literary History* 1 at 8-9.
26 Ibid at 9.
28 Tolstoy, op cit n 2, pp 18-19.
29 Ibid, p 38.
It is a truism that judgments, literary texts and medical notes all communicate through the medium of words. How these types of texts are to be interpreted is a common issue. The advent of the "Law as Literature" and "Literature in Medicine" movements has shown that developments in literary theory and the philosophy of language may be applied to legal and medical texts and records in order to investigate questions of interpretation.\(^{30}\)

We have previously stated that we are taking the term "narrative" to refer to a connected account of events which produces a story. Narratives in judgments, medical records and literary texts are usually structured to integrate "the multifarious episodes of remembered past into one coherent ... story".\(^{31}\) Narratives in judgments, medical records and in literary texts form stories out of the way in which the "facts" are presented. The content of judicial and medical narratives springs inevitably from real, rather than imaginary, events invented by a narrator, yet the narrative form in general arises from a desire to make sense of the world:

"Narrative is one of the ways in which we speak, one of the large categories in which we think. Plot is its thread of design and its active shaping force, the product of our refusal to allow temporality to be meaningless, our stubborn insistence on making meaning in the world and in our lives."\(^{32}\)

Barthes writes that "art knows no static".\(^{33}\) In other words, the narrative form places events into a structure in which anything perceived as extraneous is eliminated. This structure differs from "life" in which everything is "scrambled messages" (communications brouillées).\(^{34}\) In law, as in medicine, this process is crucial, for decision-making is shaped by comparing "the narrated circumstances of the present case with others of more or less the same kind".\(^{35}\)

It has even been argued that literary narratives in this existential sense have a diagnostic or medical function:

"Without denying the overwhelming evidence that readers do take explicit instruction from even the least sermonic works, I would argue that a much more important moral effect of every encounter with a story, good or bad, is the practice it gives in how to read moral qualities from potentially misleading signs."\(^{36}\)

**Historical narratives as an illustration of the process of “Chinese whispers” in judicial narratives of medical cases**

Historians have traditionally stated that their purpose is to construct "true" accounts of the past. It is now accepted, however, that published historical narratives such as those by Gibbon on the Roman Empire,\(^{37}\) Carlyle on the French Revolution,\(^{38}\) Churchill on the English speaking peoples\(^{39}\) and Manning Clark on the development of white civilisation in Australia,\(^{40}\) also have a regulatory function: to retell the facts of the past to encourage a particular vision of the future.

The use of the narrative form to relate discrete events is pervasive in historical studies. In the last two decades, however, a dispute has occurred as to whether the use of the narrative form by historians is to be tolerated or condemned. This dispute is relevant to the process of serial distortion of the facts in judicial narratives of medical cases.

Hayden White\(^{41}\) has been the foremost critic of the use of narrative in contemporary historical

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\(^{33}\) R Barthes, "Introduction à l’analyse structurale des récits" (1966) 8 Communications 1 at 7: "On pourrait dire d’une autre manière que l’art ne connaît pas le bruit (au sens informationnel du mot)[In another way, one could say that art knows no static (in the informative sense of the word)]."

\(^{34}\) Ibid.

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\(^{35}\) Hunter, op cit n 22, p 149.

\(^{36}\) Booth, op cit n 20, p 287.


\(^{41}\) H White, "The Question of Narrative in Contemporary Historical Theory" in The Content of the Form: Narrative Discourse and
texts. He argues that the “fact that narrative is the mode of discourse common to both ‘historical’ and ‘nonhistorical’ cultures and that it predominates in both mythic and fictional discourse makes it suspect as a manner of speaking about ‘real’ events.” His treatise is based on the view that real events do not proceed in a narrative way. If they are treated as forming a story with a beginning, a middle and an end, that story will be untrue to life. In virtue of its very form, narrative will present a distorted picture of the events it relates. White argues that the traditional representation of real events in narrative form “arises out of a desire to have real events display the coherence, integrity, fullness and closure of an image of life that is and can only be imaginary.”

This argument that narrative in historical texts leads to misrepresentations of reality, though it applies to medical narratives, applies most particularly, for our purpose, to judicial narratives. It is difficult to deny that judges create “the facts” in their judgments in that they always select certain events out of a profusion of details which have already been winnowed by the legal process, in order to give a coherent chronological account of what occurred. The frequency with which multiple opinions (not necessarily due to dissent) in appeal cases give different versions of the facts is a reminder that this is the case. Trial judges also take care to set out a comprehensive chronological sequence of events in order to avoid subsequent appellate findings that they failed to take into account relevant evidence. In creating a particular version of events, judges also have the benefit of hindsight which enables them to give a plausible retrospective account of what occurred. As Sartre points out:

“When you tell about life ... you seem to start at the beginning... But in reality you have started at the end.”

Events in life “can be out of sequence, random, purely accidental, without purpose“. Events in judgments are ordered, purposeful and coherent. It is this transformation that underscores the process of “Chinese whispers” or the serial distortion of clinical information. In order to show how this may reduce the regulatory effectiveness of the common law, we turn to an analysis of two important recent medical negligence cases.

Judicial narratives in medical negligence cases

The facts in the New Zealand case of R v Yogasakaran are set out by Cooke P who delivered the judgment of the Court of Appeal. They take up almost a page while the discussion of the law takes up over seven. Yogasakaran was an important regulatory decision for the medical profession in New Zealand because it confirmed that under the prevailing interpretation of the Crimes Act 1961 (NZ), an anaesthetist could be guilty of manslaughter where his or her “ordinary” or “civil”, as opposed to “gross”, negligence was causally responsible for a patient’s death. The judicial narrative comprising the published judgment in the case (and subsequent cases applying it) resulted in a substantial change to clinical medical practice; “difficult” anaesthetic cases were postponed or cancelled, accident reporting was reduced and many anaesthetists left the field or the country. Given this regulatory importance, it would be thought that the judicial narrative would have been written with a medical audience in mind. That this was not so will be emphasised by the italicised comments in parentheses inserted in the following reproduction.

42 Louis Mink more reluctantly reaches some of the same conclusions as those of Hayden White: L O Mink, “Narrative Form as a Cognitive Instrument” in R H Canary and H Kozicki (eds), The Writing of History (University of Wisconsin Press, Madison, 1978); L O Mink, “History and Fiction as Modes of Comprehension” (1970) 1 New Literary History 541.
45 A M Dershowitz, “Life is Not a Dramatic Narrative” in Brooks and Gewirtz, op cit n 15, p 100.
47 Ibid at 401.
48 R v Morrison (unreported, High Court, Dunedin, S7/91, 23 April 1994, Fraser J); Long v The Queen [1995] 2 NZLR 691.
of the facts in the appellate judicial narrative in Yogasakaran.50

"This case arises out of a tragic accident which occurred in the Te Kuiti Hospital on 16 September 1987. A woman had undergone gall bladder surgery.

[Was it an open or laparoscopic cholecystectomy? Was it a long or short procedure? Were there any complications?]

For a number of reasons she was a high-risk patient.

[What reasons? If these reasons, for example, related to her respiratory or cardiac function they provide a vital clue to what subsequently transpired.]

After the operation [How long after?], while she was still under general anaesthetic

[Was she still paralysed as well as sedated? Was she in the operating theatre or in the recovery room? How was she being monitored? ECG? Capnography? Pulse oximetry? Central venous pressure? Arterial blood pressure? Was a recovery nurse with her?],

an emergency arose. She was biting on the tube in her mouth and having difficulty in breathing.

[Were her oxygen saturation levels falling and her carbon dioxide levels rising? Was her chest wall motion symmetrical? Did she have good air entry to both lungs? Was the endotracheal tube still properly positioned? Were her vital signs stable?]

Dr Yogasakaran, the anaesthetist, quickly decided to inject her with a drug called Dopram (a trademark for a preparation of doxapram hydrochloride). The evidence is that this was a proper method of treatment.

[What evidence? This should be stated expressly because Dopram, a respiratory stimulant would be regarded by many as a poor second-line choice in this situation. Many anaesthetists would choose to paralyse the patient with 1mg/kg iv of the rapid onset, short duration, neuromuscular blocking agent succinylcholine and then hand ventilate once the muscle spasm had subsided. The evidence for the use of Dopram in this situation would need to be evaluated by a medical audience for validity before this part of the judicial narrative could be accepted.]

He opened the top drawer of the anaesthetic drugs trolley and from among the array of drugs he took a packet.

[What was the atmosphere of the situation? What was he thinking and feeling when he did this? The judgment later mentions he was "in haste" but no explanation is given as to why. The judgment does state that the anaesthetist failed to give evidence at the trial which may explain in part how the legal process caused the facts to become distorted in the published judicial narrative.]

In a number of statements he has consistently said that it was in the drawer at the place labelled Dopram; the prosecution has not disputed this and there is no evidence to the contrary. Out of the packet he took one of five plastic containers, peeled off at least partly the lid of that container and removed a plastic ampoule, inserted and filled a syringe and injected the contents into the patient.

[How much was injected? How much did the patient weigh? Did the patient have a known history of drug reactions? Had the patient received that drug before?]

In fact, unknown to Dr Yogasakaran, the drug was not Dopram but Dopamine (more fully, dopamine hydrochloride, also known by the trademark Intropin). It was entirely unsuitable for the purpose [Why? What was the evidence for this conclusion?] and administered in this quantity [What quantity?] was a massive overdose. The patient died in consequence."

[How soon after the injection? What else was done to the patient before death? No reference is made to the emotional or subjective factors which may have led to the decision to administer this drug. No mention is made of whether or not any individuals showed panic or moral courage in how they dealt with such an emergency. Such facts are surely not irrelevant even to an appellate court giving due consideration to its regulatory function.]

The judgment continues to explain how Dopram and Dopamine are packaged and goes on to analyse the relevant provisions of the Crimes Act 1961 (NZ) and make a pronouncement upon their

50 (1990) 1 NZLR 399.
applicability. No attempt is made to set out systematic guidelines whereby such accidents could be avoided in the future. It appears that the members of the Court of Appeal viewed the sole purpose of this decision to be the resolution of questions of law relevant to the dispute between the parties. The regulatory implications of this decision were simply ignored. The question needs to be asked: why should this be the case? What rationale is there for ignoring the appropriate audience for such judgments, namely those health care professionals obliged to follow judge-made law in order to improve safety for their patients?

Rogers v Whitaker\(^\text{51}\) is a key Australian medical negligence case in which the High Court held that a medical practitioner has a duty to warn a patient of the material risks inherent in proposed treatment options. What constitutes a material risk is to be assessed by a patient-oriented test; namely, whether "a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it" or whether the patient indicated a desire to be informed of other particular risks.\(^\text{52}\) This decision marked a move away from English law which emphasises a professional practice standard for the assessment of whether or not a medical practitioner has been negligent.\(^\text{53}\) Mason CJ, Brennan, Dawson, Toohey and McHugh JJ commenced their judicial narrative as follows:

"The appellant [an ophthalmic surgeon] advised [Maree Whitaker] that an operation on the right eye would not only improve its appearance, by removing scar tissue, but would probably restore significant sight to that eye. At a second consultation approximately three weeks later, the respondent agreed to submit to surgery. The surgical procedure was carried out on 1 August 1984. After the operation, it appeared that there had been no improvement in the right eye but, more importantly, the respondent developed inflammation in the left eye as an element of sympathetic ophthalmia. Evidence at the trial was that this condition occurred once in approximately 14,000 such procedures, although there was also evidence that the chance of occurrence was slightly greater when, as here, there had been an earlier penetrating injury to the eye operated upon. The condition does not always lead to loss of vision but, in this case, the respondent ultimately lost all sight in the left eye. As the sight in her right eye had not been restored in any degree by the surgery, the respondent was thus almost totally blind.\(^\text{54}\)

A major factual omission in this judicial narrative is the lack of citation of the evidence supporting the figure of a one in 14,000 risk of sympathetic ophthalmia. The names of the relevant expert witnesses cited in the judicial narrative of the trial at first instance\(^\text{55}\) are not given and there is no mention of the scientific evidence upon which such experts relied. While it could be argued that such facts are more appropriately set out in judgments at the trial rather than at the appellate level because they may not be strictly relevant to questions of law argued on appeal, the audience for appellate judgments again needs to be considered. Lack of research citation is an important distortion of the relevant facts for medical practitioners as it effectively prevents them from independently evaluating the scientific basis for the patient-oriented standard of care. From a medical perspective, it is in fact extremely difficult to ascertain the incidence of sympathetic ophthalmia because the condition has no conclusive diagnostic investigation or serological marker, the diagnosis being based solely on clinical symptoms and signs. The reported incidence of sympathetic ophthalmia has in fact ranged from 0.19 per cent following penetrating injuries to 0.007 per cent following intraocular surgery and previously from 0.54 per cent to 17.5 per cent with an average of 2 per cent.\(^\text{56}\) To substantiate even these statistics,

\(^{51}\) (1992) 175 CLR 479.
\(^{52}\) Ibid at 490.
\(^{53}\) Bolan v Friern Hospital Management Committee [1957] 1 WLR 582; Sidaway v Board of Governors of Bethlem Royal Hospital [1985] AC 871.
\(^{54}\) Rogers v Whitaker (1992) 175 CLR 479 at 482.
however, the methodology of these studies would need to be evaluated. Citing scientific evidence in an appellate judgment does not appear to be an onerous task and would be of great assistance to those health professionals obliged to follow judge-made law.

Because of the vital clinical information left out of these final judicial narratives and the way in which the remaining information is expressed and structured (without tables, photographs, diagrams or research citations), they are virtually meaningless, in a regulatory sense, to the medical profession. It is not a sufficient answer to this lack of clinical medical detail to say the judicial narratives have declaratory or punitive functions in individual disputes rather than a broader regulatory function. Both Yogasakaran and Rogers v Whitaker were highly publicised and the courts must have been aware of their significance to future conduct among the medical profession. Neither is it an answer to say that the missing information could be obtained by examination of the transcripts of the trial and the depositions of witnesses. This is an arduous and expensive process even for a legally trained person familiar with court bureaucracy. It is beyond what can be expected of a reasonably busy medical practitioner. Leaving the process of full explanation to continuing education courses for health professionals would amount to an abnegation of responsibility by the judiciary which could lead to even further distortions of meaning.

It is also not a valid argument to say that medical practitioners are not entitled to know the minute medical facts of each case or the exact sources of medical evidence upon which the court is relying. Medical practitioners are trained to base clinical decisions only on substantiated information. If they are unable independently to validate the information on which the court has based its decision, they are simply unable to accord that decision respect. Blind faith in the “rightness” of judicial narratives is inappropriate in situations where patient safety is at issue. Is it so revolutionary to suggest that judges become more conscious of the regulatory potential of their decisions?

Conclusion

We have outlined how medical “facts” progressing through the legal system undergo a process of transformation similar to the game “Chinese whispers”. This process may result in the final judicial rendition at the appellate level of a particular medical situation having little regulatory relevance for health professionals.

It is important first to recognise the way in which judicial narratives are formulated. In this regard, we have outlined the similarities and differences among judicial, medical and literary narratives. Recent critiques of historical methods also cast light on this process of narrative development. Only after judges at all levels become aware of the process of distortion by which facts are told and retold until they form a final “narrative”, can any constructive changes take place.

The next step in relation to judicial narratives in medical cases is for such narratives more fully to take into account the audience of health professionals to which such judgments ultimately relate. We urge the creation of judicial narratives in medical cases which are more attuned to their regulatory function, more prepared to cite the medical evidence on which they are based and more prepared to acknowledge medical detail. We urge that, instead of clinical detail being progressively eliminated and clouded by its progress through the legal system, it should be highlighted so that the final whisper to the medical profession by a judicial narrative in a medical case is not irrelevant to those meant to act upon it in the interests of patient safety.


57 The establishment of specialist medical tribunals composed of both legal and medical representatives to deal with claims against health professionals might go some way in addressing the problem. It may be that such tribunals could lead to judgments which are more attuned to the regulatory aspects of the law for health professionals. However, this would require a complete reorganisation of the medico-legal system which appears unlikely in the near future.