# INFORMATION DISCLOSURE, CONSENT TO MEDICAL TREATMENT AND THE LAW

by

SHEILA ANN MANSON McLEAN

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# ABSTRACT

Medicine plays an important role in human life. It may serve to enhance or re-establish the health of an individual, and may shape the extent to which he or she can participate in the essentials of life. Thus, it may predict or assist in the level of self-determination which a person may exercise. It is argued here, however, that self-determination is also an important value within the medical act, and that - albeit unwittingly - medicine and its practitioners may also effectively reduce the individual's capacity for autonomy by withholding information which is important for the patient's capacity to make knowing and free decisions.

Thus, an attempt is made to establish that there is, or should be recognised, a right to information - a right which belongs to the patient and which is a precursor of the doctor's corresponding duty to disclose. Indeed, it is argued that such a right is currently recognised as having importance. However, from the perspective of the individual, if this right is to have concrete meaning, it must be capable of effective vindication.

Having sought to establish the value of the right, and its pervasiveness, certain special categories of patient are considered in more depth - namely, the mentally ill, the mentally handicapped and children - since it is conceded that, if the right described does not apply to these groups then its very universality is threatened and its standing in the hierarchy of important interests may be minimised. It is concluded, however, that the law at present does not deny the value of autonomy in medicine even in respect of these groups who might otherwise be thought to be vulnerable to denial of autonomy. A comparison of different legal systems shows fluctuations in the extent to which protection is offered, but it is not doubted that value is placed on extending this right to these groups. It is asserted, therefore, that the law does not and need not approach even these most complex situations without bearing in mind the crucial significance of the right and demanding considerable justification for its denial.

Whilst acknowledging that many disputes are settled outside of courts of law, it is argued that the role of the law cannot be underestimated, since even out of court settlements are generally made only after known legal criteria are met. Thus, it is claimed, if the patient's right is to be acknowledged then it should be given a legally recognised status. Moreover, it is crucial that an appropriate form of action is made available for vindication of any right.

Thus, the thesis goes on to examine the major legal actions available - assault, negligence and no fault liability. Comparisons are made with the systems and decision-making approaches of courts in Scotland, England and the United States, with some reference also to Canadian judgements. Particular account is also taken of the Accident Compensation Scheme in New Zealand. It is concluded that current legal approaches are relatively unsatisfactory in terms of their capacity to give precedence to the rights of patients. Dissatisfaction with these systems stems from two sources - in some cases (e.g. negligence) the pattern of decision-making described is essentially inimical to the demand for information disclosure. In others (e.g. assault and the no fault system in New Zealand) there are structural difficulties which ensure that rights vindication cannot uniformly be achieved.

The thesis concludes by tentatively hypothesising alternative strategies for the law, which would permit the serious attention, which it is argued is merited by this right, to be extended to it. It is suggested that there are a number of possibilities available if the law is prepared to acknowledge the value of the right described. In Scots law, the <u>actio</u> <u>injuriarum</u> may provide a possible source of redress, whilst in English law the uncertainties surrounding the manner in which tort law has developed make it more difficult to envisage radical reform. However, the negligence action remains a possible source of redress for grievances a) if the purely professional aspects of the physician's role are separated from the moral obligations imposed on any professional to respect the integrity of his or her client, thus permitting decision-making which reflects

the source of the harm rather than concentrating on the technical conduct of therapy, and b) if the law concedes the value of self-determination in medicine

# PREFACE

The hypothesis that there is a fundamental right to information disclosure in medicine, as an aspect of the more general right of self-determination, is tested primarily by reference to the sane, adult human being. Thus, except where otherwise stated, he or she will be taken to be the paradigmatic patient. It is acknowledged, however, that other groups have importance for the claim that such a right should be vindicated. Thus, consideration is made of some of the special situations in which the right may be challenged. The groups selected comprise children, the mentally ill and the mentally handicapped.

The writer has deliberately excluded consideration of the unconscious patient, since, it is submitted, the characteristics and difficulties which apply in this situation can be distinguished from those which apply in the cases considered. This is not to imply that the unconscious patient does not equally have access to the right, but merely to indicate that in this situation the immediate considerations which apply relate rather to necessity than directly to the right here described. In any event, the legal position of the unconscious patient seems relatively uncomplicated, particularly where therapy is life-preserving. Accordingly, it was not felt to be essential to include specific consideration of the position of the unconscious patient, partly on grounds of space, but particularly because the aim of the thesis is to define the right and to consider the efficacy or sensitivity of legal systems in respect of its vindication. In seeking to present an analysis of the extent to which the law is capable of protecting this fundamental right, the assertion that the law both should and can do so is taken to apply to all groups of patients. The groups selected for special consideration were chosen because of the peculiar complexities of their situation within the context of an autonomy based analysis.

The discussion begins with a consideration of the role of medicine. Chapter 1, therefore, considers the potential of medicine both to enhance and to delimit the autonomy of the individual, and introduces the question of patients' rights. Chapter 2 goes on to consider the question of information disclosure and consent to treatment in more depth, and seeks to establish and describe a right to information disclosure which, it is argued, should be given legal recognition. However, the chapter concludes that, even if the right described _is_ taken as having value, its vindication depends on the capacity or willingness of legal process to recognise infringement as a legally protected interest. Moreoever, whilst it is clear that the right is currently accepted by law as having significance, legal process must also make available an effective mechanism for its vindication, otherwise the right has merely symbolic or limited value.

The mechanisms available to the aggrieved patient have changed over the years, and the next section of the discussion goes on to consider a range of available legal responses, and tests their efficacy as systems of redress against the underlying assumption of the importance of the right. Chapter 3, therefore, considers the now largely obsolete option of raising an action based in assault, and concludes that, whilst showing overt promise as a means of concentrating primarily on the rights of patients, it is inherently flawed, since it's capacity to recognise non-physical invasions of integrity is apparently limited. Chapter 4 considers the negligence action in general, since this is now the most common, and in some cases, the only avenue of redress available to the patient.

The negligence action, it is concluded , is, by its very nature, not ideally suited to the vindication of individual rights, since it depends on descriptions of duties, and rationalises behaviour in a theoretically objective manner which does not lend itself to the outright vindication of rights. In Chapter 5, emphasis is placed on the application of the negligence action in respect of information disclosure. In particular, consideration is made of the development of consent doctrines in the United States. It is argued that, even in those States which adopt the 'prudent patient' approach, use of negligence rather than an alternative analysis distances the matter of concern from the individual patient and his or her rights in a way which is unsatisfactory for those who would argue for the direct application of rights to information disclosure as a prerequisite of real consent. In Chapter 6, the situation in the United Kingdom is reviewed, and it is concluded that British Courts have traditionally shown considerable deference to the professional test when considering medical behaviour. Moroever, it is argued that the flaws in negligence analysis are compounded by the importation of extra-legal factors into decision-making. Without alteration in judicial attitudes, and unless the right at issue is given priority, it is, therefore, concluded that the application of the negligence action in British Courts is inimical to recognition of the right described.

Although assault and negligence remain the two most obvious legal processes available to the patient, at least one jurisdicition - New Zealand - has instituted a radical and novel system of liability which is effectively designed both to recognise the involvement of the community with all of those who are disabled, and to provide some form of redress and rehabilitation in the event of damage. The system is therefore reviewed in some detail in order to assess whether or not it provides a framework which would be more appropriate in medical cases in general and information disclosure cases in particular. It is concluded that, although there seems to be a reluctance to equate medical accident or negligence with 'medical misadventure' (the qualifying criterion), nonetheless this depends on the attitudes of decision-makers, and can therefore be modified. However, in respect of failure to disclose sufficient information, the system offers no incentive to make disclosure, and indeed cannot accommodate the provision of redress where the damage caused amounts to an insult to integrity rather than physical damage. The scheme is, therefore, unsuited to the vindication of the right here described.

In Chapter 8, the discussion moves on to consider the extent to which the right may be said to be generally applicable, since the fact that legal process to date seems to deal with it relatively unsatisfactorily, may be less significant if the right in fact is only of limited application. Thus, special groups - children, the mentally ill and the mentally handicapped - are considered in some depth, in order to assess whether the right either could or should be extended to them. If it is conceded that the right is of major significance, then their exclusion would both deny them autonomy enhancing information and would seriously affect the extent to which the right can be taken seriously. It is concluded that the law already is prepared to extend the right to cover at least some members of these groups, and that accepting its importance would further extend its application.

In Chapter 9 a brief assessment is made of the capacity of the law to develop sufficiently to take account of the primacy of self-determination in the medical enterprise. It is concluded that overt and unequivocal protection of the right is necessary in order that legal process can incorporate its vindication. This can be achieved either by the use, for example in Scots Law of the actio injuriarum, or - perhaps more simply - by adopting a distinction between the technical aspects of the physician's role and the moral aspects. Whilst good medical practice would ideally draw no such distinction, the law may be required to do so when assessing matters of information disclosure, which supersede the technical and guarantee the morality of the medical act.

# INTRODUCTION

## CHAPTER 1

Over the last few decades, the practices, claims and aspirations of orthodox medicine have come under scrutiny as never before.[1] The individual doctor is seen less as a favoured friend and a devoted healer, and more as a specialist participant in a system whose impressive battery of weapons will serve the health of the world.[2] Orthodox medicine has a wide variety of sophisticated tools - routinely paraded before an awestruck public - with which to decide who is ill, to provide diagnosis and prognosis and to cure (or at least alleviate) many of these conditions. Of course, nothing is perfect and perhaps not every illness can be cured, but medicine can at least make the symptoms less difficult to cope with.

Moreover, the rapid growth of associated industries - notably the pharmaceutical industry - has also changed the face of medicine.[3] Physician-like uncertainty and combined consideration of a given problem, have shifted to the apparent clinical certainty of drugs, tubes and sophisticated equipment. As medicine and its related industries became more and more subtle in their capacity to assess the mechanics of ill health, so the cures and the palliatives became more specifically targeted, more chemically refined. Medicine became more than an 'art' (or perhaps less than one) - it became a science, technically based, technologically equipped and distanced in terms of knowledge, understanding and comprehension from the public who became increasingly baffled, but nonetheless impressed by its sophistication.

Moreover, orthodox medicine in its struggle for professionalism, notably throughout the nineteenth century, significantly affected many aspects of the life of every citizen. It is widely believed, for example, that the rise of professionalism in medicine, made a significant, if not determinative, impact on laws relating to abortion.[4] Orthodox medicine played a major role in the downgrading of what is now known as 'alternative' medicine,[5] with the implication that it is fringe medicine - not the real thing at all. But, perhaps even more significantly, orthodox medicine seemed to have adopted a particular posture - namely interventionist rather than preventive. This trend has not been substantially reversed, ensuring (or at least contributing to the fact) that the vast majority of people in countries with orthodox medicine turn to it to cure or alleviate illness rather than to prevent it. In this way, and perhaps partially for this reason, the panoply of medical skills is significantly weighted towards sophisticated diagnostic techniques, and expensive high technology equipment, and medicine has looked to the pharmaceutical industry to provide many of its cures and palliatives.[6]

These points are significant within the context of this discussion, since it will be necessary to conclude that without challenging the absolute 'good' of orthodox medicine, without challenging the concepts of health and illness, and without a healthy scepticism of orthodox medicine's health care monopoly, then autonomy reducing practices may more readily be justified. Moreover, the influence of the technical nature of much of modern medicine should not be underestimated as a factor in at least some of the problems currently confronting the doctor/patient relationship in many countries. In particular, the increasing sophistication of medicine may cause communication problems between doctors and patients.

In those so-called developed countries in which orthodox medicine has a virtual monopoly of health care, the phenomenon of challenge through complaint or litigation is playing an increasing role.[7] The doctor in some jurisdictions may find him or herself constantly afraid of legal challenge whilst the patient may find that his or her status as patient can minimise personal autonomy. If, as is routinely said, trust is essential to a 'good' relationship between doctor and patient then a 'good' medical act can only follow where such trust genuinely exists.[8] Indeed, one of the major reasons to fear the 'American disease' of litigation explosion is precisely that its impact on the beneficent relationship between doctor and patient is so dramatic as effectively to reduce the potential for trust, and therefore for a 'good' medical act, which should be the aim of both parties to the interaction. Kennedy,[9] amongst others, has criticised what he calls the engineer/scientist model of medicine, seeing it as both personally unsatisfactory for the patient (perhaps also for the doctor) and therapeutically of limited value. What is claimed here is that the nature of the medical enterprise is greater than merely its technological capacity, and extends into more personal and less easily measured realms of morality - in particular respect for persons.[10] Achieving a level of trust in any relationship depends on respect between the parties, and whereas the patient routinely respects at least the technical skills of the physician (otherwise why seek him or her out), respect must also be shown by the doctor to the patient.

Viewed in this way, medicine is not simply an exercise of purely clinical skills. It transcends the technical to reach the level of morality by the sharing of respect. Indeed, medicine has long been concerned with questions of ethics, and has long shown a commitment to morality in dealing with the patient - however incomplete it might be seen by some as being. Moreover, much of this commitment relates to recognition of the need to view the patient as an autonomous human being, with rights and interests which are identifiable independently of medicine. Recent codes of practice, for example those promulgated by the World Medical

Association,[11] have explicitly dealt with the human subject in terms which leave no doubt as to the status to be accorded to the patient. Although this commitment is traditionally more clear in cases where the likely nature of the interaction is experimental,[12] it remains sound and appropriate in whatever situation the doctor exercises his or her professional skills.

Medicine's response to its patients is not merely an academic question, since at one time or another (and in some cases frequently) each of us will have some contact with orthodox medicine. Indeed the increased longevity to which many people in the developed world can aspire, will likely have a significant effect on our experience of medicine. This is primarily because - whatever our life-expectancy - age brings with it apparently inevitable problems. High technology may be able to provide pain relief for the chronic conditions associated with the elderly, such as arthritis, but it seems neither able to prevent nor cure it. Given the monopoly which orthodox medicine has in health care, even pain relief for the chronically ill will generally be sought through contact with orthodox medicine. The increasing number of elderly in the community is likely therefore to mean that - as a community of nations - the <u>per capita</u> contact with medicine will increase.

A substantial number of prescriptions are issed in the United Kingdom each year.[13] There is no obvious reason to think that this number is decreasing, and indeed measures have recently been taken to attempt to limit the drug bill in the National Health Service.[14] This means that, despite the claim that a substantial proportion of illness is self-limiting,[15] many more consultations result in the issuing of a prescription.[16]

Moreover, increased media attention, increased publicity by doctors themselves and the political capital which can be made by being ahead in the race for better cures, more exciting surgical techniques, control over life and death and so on, meant that medicine was constantly paraded before the public in dress uniform. Its successes were trumpeted - its failures often ignored. This apparent imbalance may have represented no more than a desire to view only the positive, perhaps for a variety of reasons, but it also resulted, whatever its motivation, in an exaggerated and potentially problematic perception of medicine as something which is not only always good and well-motivated, but also always successful, or at least always showing enterprise, awe-inspiring skills and an understanding which goes beyond that which could be expected of ordinary mortals. The current trend of parading medicine's failures has further dramatised the practice and capabilities of medicine in a manner which is scarcely helpful.[17]

This proliferation of claims about orthodox medicine, and therefore by implication about the doctor, may result in a number of phenomena, many of which are inimical to the morally good practice of medicine. The patient may become humble, undemanding and uninvolved with his or her treatment. Indeed it has been said that:

> Although scholars have proposed various models to describe or prescribe the distribution of power within the doctor patient relationship, for a number of years one view dominated professional ideology and customary practice. Under that view, the patient was seen as making only one key decision, to place herself in a given doctor's care, thereby delegating all subsequent authority to the doctor. Such a model assumed that the patient lacked the technical ability to make medical decisions and their expertise justified the doctors making decisions on the patients' behalf.[18]

Since much treatment is enhanced by the active mental co-operation of the patient (indeed it is now becoming part of accepted therapy that the positive involvement of the patient can be beneficial),[19] patient participation is seen as very significant, but is unlikely to be achieved in a relationship between a masterful doctor and a cowed patient. Further, the doctor may increasingly come to regard his or her skills as so far removed from the ordinary patient's understanding and experience as to forget that the use of these skills results in human and not solely technical consequences. The former of these the patient not only can understand but also must live with.

The technical revolution has also had further significant implications for doctors and patients. As the gap in technical skills widens, so the difficulties of communication inevitably increase.[20] Equally, however, the expectations of the patient are increased, resulting in disaffection with the medical act which does not succeed - a disaffection which is likely to be all the greater if not canvassed in advance as a possibility. In other words, communication may seem paradoxically to have become more difficult and yet more significant. This significance is, however, not just moral. Patients may be more impressed by the panoply of medical technology, but citizens in general are equally more aware of their civil rights. Challenge can lead to hostility, and yet is more likely in a rights conscious community. Moreover, it is more likely where explanations, communication and discussion are sparse or absent.

This is not, however, to suggest that the exercise of purely technical skills is not highly important. Indeed, perceived failure to exercise professional skills properly remains the major source of challenge in medicine, as in other disciplines. However, the expectations generated by the claims of orthodox medicine are merely one set of expectations which the patient may have. Rights consciousness also raises expectations of involvement and of dialogue, and the fact that it is the patient and not the physician whose health is in issue, raises the expectation that the patient will or should be intimately involved in his or her therapy.

Moreover, medicine as currently practised, is a high risk enterprise. No drug, for example, is entirely safe, and risks attach to diagnostic and therapeutic techniques. Even the most technically proficient medical act cannot guarantee complete success, nor can it be assured that unsought side effects will not occur. Communication, therefore, becomes important at a further level. Not merely does it permit of the establishing of a therapeutic bond between doctor and patient, but it permits the patient to have a reasonable awareness of the possible outcome of therapy or of diagnosis. Thus, not only does it allow for free decision making on the part of the patient as to whether or not to become involved in the medical enterprise, but it can also serve to minimise the disappointment and ill-feeling which can result from a short-fall between expectations and results.

Recognising the significance of communication between doctor and patient is a fundamental step in generating a therapeutic atmosphere capable of respecting the rights of the individual patient. The doctor who ignores or minimises the importance of patient involvement places his or her position at risk. The number of actions raised against the medical profession continues to rise,[21] and the impact of this on medical care cannot be underestimated. It has been said the the raising of an action against a doctor is the archetypal expression of patient dissatisfaction.[22] However, dissatisfaction may be with the outcome of the medical act rather than with the technical skill demonstrated by the particular doctor. Thus, many challenges may stem as much from a failure to explain known risks as from the doctor's operational mistakes or negligence. Moreover, failure of communication denigrates the patient's status as an autonomous individual and represents an insult at the abstract, but highly significant, level of morality. A 'good' medical act - the desired outcome of all consultation and treatment - is inconceivable if it is not consensual. It is here that the consent of the patient becomes most significant. Medicine must be encouraged both to practice its skills to a high standard and to deal with patients at a morally acceptable level.

## Medicine and Technical Skills

As with most groups in the community, challenges against the medical profession have traditionally arisen through a perceived failure on the part of individual professionals to exercise their skill at the expected standard. This standard is higher where, as with doctors, the individual holds him or herself out has having special skills and a high level of expertise.[23] Each group in the community professing a trade or profession is expected to demonstrate a reasonable level of care and attention when practising its art or science. When the enterprise is particularly risky, then a higher standard of care is expected by law and by the consumer.[24] As a high risk enterprise, expectations (both legal and personal) of medicine are particularly high - at least in theory. This results not merely from the fact of the risk element but also from the value placed on health - the guardians of which, in the developed world at least, are routinely perceived to be orthodox medicine and its practitioners.

The status of the individual as healthy or ill is not value free - indeed it can be highly significant.[25] Thus, the diagnosis of ill-health (which again is generally the monopoly of orthodox medicine) may have a profound effect on the individual at a number of levels. At one level, the individual's self-perception is altered by the fact of illness, his or her personal and social capacities can be severely limited by the knowledge of the illness and its nature. At another, certain forms of illness can have even more significant results. The diagnosis of mental illness, for example, which has been described by some as highly speculative,[26] may result in loss of freedom, loss of opportunity to form relationships (particularly sexual relationships), loss of capacity to enter into legally binding agreements and perhaps more significantly, in extreme circumstances may result in the person so diagnosed being precluded from participation in the democratic process. Medicine, therefore, plays a political as well as a personal role and its importance is thereby enhanced. The person who seeks medical advice, therefore, may also place himself or herself in a situation of vulnerability beyond that which is generated by the mere fact of illness. Whilst this does not mean that contact with medicine is dangerous in se, it does suggest that the morality of the medical act and the adequate use of skills within it, have significance beyond the narrowly technical.

Issues concerning the application and definition of medical skill will be considered later,[27] but it is worth noting at this stage that the law has recognised the significance of professionalism in ethical terms and respect for individuals at the moral level, by having developed rules which relate to the negligent performance of duties[28] and - in the medical context - rules about the provision of consent to treatment.[29] Some jurisdictions have also become relatively sophisticated in their handling of the other side of the consent coin, that is, its withholding.[30] The medical profession itself has recognised its vulnerability, and its responsibility, by the establishment of defence organisations, which - although not technically classed as insurance companies - provide a sort of insurance service for doctors.[31] However, in addition, they offer a service to the patient (funded by doctors themselves) in that indefensible cases, and cases thought likely to succeed, can be settled without the need for the patient to become involved in potentially protracted litigation where there is evidence of a legitimate grievance. Just as in courts of law, the decision as to the capacity to defend a given case is generally made by reference to legal rules, although in same cases, it has been suggested that other factors also play a role in the decision to settle.[32]

In its traditional role as balancer of interests in disputes, the civil law plays a fundamental part in setting the standards to which practitioners of medicine (and of course all citizens) are expected to aspire. Failure to achieve the level set by law, coupled with damage resulting from this failure, will result in an award of damages designed to place the injured party in the position he or she would have been in but for the negligence involved.[33] There are a number of possible methods for obtaining redress which will be dealt with in more detail in later chapters.[34]

As noted above, the majority of challenges to doctors arise from a perceived failure in that aspect of their practice which relates to the nature and quality of technical skills. Judgements are concerned with the doctor's professional competence - routinely narrowly conceived as relating to the manner in which technical matters are effected. This is of course no less true of other professions or groups in the community. The fundamental duty of the doctor can, then, be described as being to exercise the technical expertise possessed reasonably, in line with what can be expected of other doctors of similar standing. However, despite assertions that doctors are judged by the law as we all are, there are additional difficulties in reaching judgement in these cases. The increasingly specialised nature of medicine makes it more difficult for courts to assess what the reasonable doctor knows or should have been able to achieve. Thus, a number of eminent lawyers have remarked on the difficulties of assessing technical skills, and even of understanding technical (and apparently inevitably jargonised) evidence.[35]

The assessment of clinical behaviour will be discussed in depth later,[36] but is is worth pointing out at this stage that the perceived difficulties of assessing most professional behaviour without possession of the skills oneself renders accountability of professional groups problematic. Accountability to the community is obtained substantially by the use of the law through the mechanism of the courts. The law sets appropriate standards, however vague, and it is against these which behaviour will be measured. For the 'ordinary' citizen, the test will be that of the 'reasonable' man[37] and for the professional, the test will generally equate to the reasonable professional at that level of skill.[38] However, whilst courts are deemed to understand in what way a reasonable man would or should behave, and also how to assess the behaviour of lawyers,[39] doctors amongst others pose more difficulties. A court inevitably has more problems in assessing the technical aspects of their behaviour, and must therefore depend heavily on the evidence of fellow professionals. Whereas no individual is permitted to testify as to what a reasonable man (or woman) would or would not have done in a given set of circumstances,[40] the sophistication of the medical act is such that others skilled in the same profession are necessary to assist in making an assessment of what level of skill it is reasonable to expect, and whether or not the person whose behaviour is currently under scrutiny can be deemed to have deviated from that level, or to have fallen below the standard which is reasonably expected of him or her. This problem is, of course, not confined to medical practice, but for the purposes of this discussion, it remains the most central area.

Nor is this the only factor which is used in cases and which has an impact on the law's capacity to perform its traditional role of interest balancing. Although it has been suggested that the role of the doctor in the community may have altered with the changing face of medicine itself, nonetheless the credibility of medicine and its practitioners remains at a high level. The image of medicine as a specially protected social good is, if anything, enhanced by its high technology image. The capacity of medicine to achieve what - in the public eye - amount to nothing short of miracles, for example in heart transplantation, ensures that it is held in the highest esteem, and that medical practitioners are viewed with the mixture of awe and deference due to the contemporary witch doctor. Nor are courts immune from this apparently unquestioning belief in the value of medicine. In many court decisions, society is reminded of the value of medicine, of its contribution to the world and of its responsibility for the common good in the shape of health.[41]

This is not an insignificant point, nor is it unrelated to the context of this discussion. Decision-making in the courts has a profound effect both on the standard set by medicine and, of course, on the rights of patients. The attitude of the law to doctors and their discipline may profoundly affect the capacity of the patient to succeed in obtaining redress for a grievance, and the tone adopted by these same courts in decision-making provides some guidelines for the professionals themselves as to the behaviour which is acceptable to society. What is clear from an analysis of judicial statements is that often, in the United Kingdom at least, a number of extra-legal criteria are used in decision making in this particular area.[42]

The use of these factors may relate to the perceived social good of medicine - by and large unreservedly accepted, although some commentators, notably McKeown,[43] Illich[44] and Szasz[45] would dispute this. However, other factors have also influenced decisions in respect of patients' claims - for example the status of the doctor,[46] the possibility of defensive medicine,[47] and so on. The burden of proof, it has been said, is higher when a challenge is made to the doctor than it is in other allegations of negligence.[48] The rationale for the significance of these factors is linked, therefore, to the status accorded to orthodox medicine and its practitioners, and thus merits some consideration.

Moreover, yet another rule of law may be affected. The normal rule is that the greater the risk of the enterprise, the higher the standard of care against which the individual will be judged.[49] However, in medical cases, the existence of this high risk is sometimes used to restrict rather than to expand liability.[50] Of course, where some of the unavoidable risks of therapy occur, there must be no necessary implication that negligence was involved. If courts confined themselves to this view few would quibble with it. However, the use of the risk factor often surpasses this relatively unexceptionable one, and results in acceptance of behaviour which might seem to be questionable. That 'we cannot accept the benefits of medical treatment without also accepting its risks'[51] need not expose the public to a high risk unless the assumptions of beneficence, benign motivation and high profile credibility are taken too far. Certainly, risks are inherent in medicine, and - if agreed to - can be accepted. However, the individual patient is neither obliged to accept them merely because medicine is thought to help many people, nor obliged to run unspecific risks in the interests of medical practice or advancement.

At the simple level, the doctor who experiments in the hope of improving standards might well elicit approval, and sympathy, even if something goes wrong, but to relieve him or her of liability because he or she did not know there could be a risk is to omit to consider one other crucial factor, namely the harm done to the patient as a result of non-standard treatment, administered without approval and without the benefit of safety requirements. Although some patient must be the first, simply to deny responsibility because medicine is a risky business, even although the particular risk was self-generated, seems legally unusual to say the least, and yet this is precisely what happened in the case of Roe v. Ministry of Health.[52] Indeed, it is plausible to argue that the risk factor in medicine is precisely why accountability is so important, and accountability is ultimately achieved through the civil courts.

So, in conclusion, it can be seen that there are a number of factors which influence legal decisions on the technical practice of medicine. Whatever their credibility, they have informed the approach of the courts to challenges to medicine, and to the assessment of the behaviour of physicians in carrying out the operational aspects of their profession. In brief, these factors seem to be the status of orthodox medicine and its contribution to the general social good, the temptation to rely heavily, if not definitively, on the evidence of fellow practitioners - a reliance which stems from the increasing complexity of the practice of medicine. The reluctance of any professional group to criticise its members in any but the most overtly negligent situation is a further contribution to the difficulties facing the pursuer who seeks to show that a doctor has been negligent. Yet, as has been said in one leading American case, fairness to the patient demands a standard set by law and not by doctors themselves.[53]

Of course, where operational matters are concerned, the law cannot set rigid standards. Professional competence will vary on a personal basis, but a general standard will nonetheless be required as a yardstick. Just as people are all tested against the mythical reasonable man, whatever the characteristics of the individual, so too the doctor is judged on a common denominator approach. Information as to what the average or standard or reasonable doctor is, or what he or she would do in a given situation, will primarily come from those who share the expertise - that is those in equal possession of the knowledge and skills of the person whose behaviour is challenged. Little wonder that courts are loath to interfere in the assessment of medical behaviour when it is made by an eminent representative of the profession itself. In view of this, that the law sets the standards is in some situations not obvious, and it seems to many to be objectionable that medicine is often apparently self-regulating even in the courts.

However, to take this view is, whilst understandable, overly simplistic.

It may, however, seem to be misleading to talk of dependence on professional evidence as a problem. Indeed, could it not be argued that only through this kind of informed decision making can the courts reasonably be expected to reach an accurate and appropriate conclusion? In any event, the courts reserve to themselves the right to make the ultimate decision, disregarding if they so choose the evidence of professionals. How often in fact this is done will be considered later.[54] In this context, however, it may seem that this caveat takes on considerable significance as a way of controlling what otherwise may be seen as merely a system in which professionals themselves assess the legal standing of their colleagues' behaviour. Indeed, were the courts not to make a stand of this sort, then their role would be reduced to that solely of calculating damages, and not of actual decision making on liability. If the evidence of fellow professionals were to be all important, then there would be little justification for expensive, protracted hearings of the sort that often arise in difficult cases such as in allegations of medical negligence, and the opportunity for public accountability of professional groups would be significantly reduced.

However, the paradox also is that where courts decide about medical behaviour relating to the exercise of technical skills, they do perceive a genuine difficulty - a short-fall of expertise which, when combined with other factors, can result in a heavy dependence on medical evidence, and render the role of the law symbolic rather than truly decisive.

The rule of law is that the value of competing evidence is a matter for the courts.[55] Whereas it has been suggested in at least one case that uncontested psychiatric evidence must be accepted by the court,[56] at least in the criminal law it is clear from the recent trial of Peter Sutcliffe that even eminent and uncontested medical (in this case, psychiatric) evidence need not be taken as definitive of legal matters.[57] However, it is also worth noting that in other situations, also involving the criminal law, for example the trial of Dr. Arthur,[58] medical evidence as to standard practice <u>was</u> deemed to be decisive even although it was of no technical relevance to the charge of murder (subsequently reduced to attempted murder). Courts, therefore, may be said to have shown a certain confusion, in the criminal law at least, as to the emphasis to be placed on medical evidence - an ambivalence that seems to relate to the nature of the desired outcome as much as it does to the value of evidence in any abstract sense.

Thus, one cannot underestimate the importance of expert testimony on the determination of whether or not the behaviour in question falls below the level of skill which can be reasonably expected of the person in question. Whilst there are practical reasons or explanations for this, it may also seem that some highly technical or sophisticated professions, such as medicine, may find themselves, however unwittingly, in the position of effectively usurping the role of the court. Moreover, these are the very groups whose professional etiquette most strongly demands that a colleague should not be publicly criticised. Thus, for one doctor to speak against another requires the most serious consideration. Professional and defence organisations alike will caution silence and the group - not unusually - prefers to keep its problems internal. In fact, at least one eminent commentator has indicated that the ultimate condemnation for a doctor is the criticism of his fellow professionals, and not censure by a court.[59] Indeed, this attitude has been accepted by some members of the judiciary, notably Lord Denning, who has been highly influential in forming the body of knowledge which makes for legal precedent and for decision making in this area.[60] In a number of cases, Lord Denning made it clear that the court should hesitate to condemn medical behaviour if other doctors would not condemn it.[61] In other words, the doctor's behaviour is most accurately and appropriately assessed by his or her own colleagues and not by the courts or by a standard generated by law. That is, the standard may be set by the law - in the technical sense that the law may insist that the standard to be achieved is not necessarily that thought suitable or sufficient by doctors - but the nature, extent and shape of medical responsibility may actually be formed by the profession itself.

Doctors, as expert witnesses, are, however, no more competent to speak to the ultimate issue than are other experts. Their business is to inform the court as to their opinion of the behaviour under challenge, that is, their opinion as to whether the behaviour meets the standard of the reasonably competent practitioner. This capacity to give opinions is what distinguishes the expert witness from the ordinary one.[62] However, the opinion which the expert is entitled to give is not in fact, or as a matter of law, an opinion as to whether or not the legal test is met. In other words, negligence is a legal and not a professional matter - in this case not a medical matter. If courts rely too heavily on expert evidence then the legal rule is in danger. Blanket acceptance of professional assessment does no good for the theory of law nor for its practice.

However, there is a certain logic - indeed it might be argued a necessity - in the significance of medical evidence in cases of medical negligence. The fact that other doctors would not criticise their colleague is informative, as will be descriptions of what the profession regards as good or competent medical practice. Inevitably, although reluctant to criticise their colleagues, doctors will also not wish to present a description of competent medicine which seems to set so low a standard as to render it not worthy of esteem. For this reason, it is likely that a balance of interests can be achieved. However, it remains the case that the law must decide not merely whether doctors think the behaviour in question was acceptable, but rather whether or not it was negligent.

Negligence is described and delineated by rules of law and is not commensurate with accepted professional conduct. Whilst the latter will be informative, there are issues involved in the decision-making of the courts which are wider in their implications than the preservation of narrowly professional standards.[63] The courts, in considering whether or not to redress grievances, are also capable of taking into account issues of justice, need and so on. Moreover, and perhaps more fundamentally, the courts must satisfy themselves that the legal requirements of a successful action are met. This is true whatever the basis on which the action comes to court.

Thus, judicial decision-making is of major importance in the ultimate assessment of the validity of a claim. Importance is therefore placed in this discussion both on the nature of the available action and on the scope which each form of action provides for the exercise of judicial discretion. Of particular significance will be the extent to which the decision-makers themselves emphasise the rule of law, and the rights of patients, or the interests and evidence of the group under challenge. At a later stage this will be considered in some depth.[64] For the moment, however, it is sufficient to consider what are the implications of the foregoing section.

## Summary

Even ignoring the extra legal factors which can - and it has been claimed, do - affect decision-making in medical cases, there remains a plausible distinction between medical and legal interpretation of a given piece of behaviour. At least, there remains this potential difference, since in theory each of the parties involved is seeking to make different assessments and to answer different questions - however subtle that difference may be. The medical expert seeks to assess his or her colleague's behaviour in terms of its clinical validity, within certain boundaries, and in the light of certain allowances. The expert will, of course, inevitably also have an eye on the impact which his or her description may have on the ultimate assessment of the court. However, it has been claimed that expert assessment need not point to the ultimate decision of the court.

In matters of technical or operational competence, it may - as has been seen - at first sight seem most plausible to argue that the best people to assess whether or not the doctor is negligent would in fact be his or her fellow professionals. After all, they are the experts in a highly specialised and technical discipline. Who better than a fellow specialist to judge such behaviour? However, it has also been indicated that the description of the doctor's behaviour as negligent or not is for the courts and not for other professionals. Nor is this a narrow academic point, since the significance of a finding that the legal test has been met goes beyond professional censure or approval. Thus, even in those aspects of the doctor's business which are intimately linked to his or her technical skills - that is, in matters often referred to as operational - the legal assessment of his or her behaviour, for the purposes of the legal system at least, cannot appropriately or competently be made merely by reference to what others in the profession might think of as good, or alternatively substandard, behaviour - however valuable this information may be.

## An Introduction to Patients' Rights in Medicine

There is a further level to the medical act which goes beyond the purely technical. Indeed, the moral aspect of medicine - as with all human interactions - cannot properly be described solely in terms of the narrow discipline. The responsibilities of the lawyer to his or her client, the psychologist, the architect, as well as the doctor, share characteristics which make it impossible to describe the factors under consideration as only 'medical' or 'legal', and so on. The level at which professional groups deal with their clients as self-determining human beings is not specific to any one discipline, but relates to the characteristics of the client as much as it does to the profession or the professional involved. Thus, whilst the nature of the technical skill which clients seek may differ, the essential characteristic of a good transaction need not change. A good act remains one which respects the client's moral autonomy (as well as being one which demonstrates the level of technical competence which can reasonably be anticipated) and facilitates his or her capacity (and right) to make free and uncoerced decisions based on the honest provision of information.

Thus, although the courts have placed heavy emphasis on medical evidence in describing the doctor's technical duty to his or her patient, does this equally apply to the moral aspect? If it is questionable when technical professional skills are under scrutiny, is it not even more questionable when the question at issue is not technical at all, but rather relates to reinforcement of a view of the individual which is treasured by national and international law and morality?[65] This is not to say that the acknowledgement of the status of the patient is not intimately tied into the provision of the technical skill being sought, but it is an aspect of the professional relationship which also transcends it. It is the right of the individual which generates the duty of the professional not to overstep authority in the name or the interests of professional skill or technical superiority. Thus, although the technical gap can seldom if ever be bridged, respect for the individual demands that relevant information is disclosed and an opportunity presented for either individual or consensual decision-making.

In the case of medicine, this provision of information permits the patient to make choices about whether to run certain risks, and what risks to run. Whilst information disclosure can easily been seen as an aspect of the doctor's professionalism, it is scarcely only an aspect of the exercise of these technical skills. Assessment of the doctor's behaviour in this aspect of medical intervention is less obviously susceptible of clinical assessment or judgement. If the aim of disclosure is the protection of individual autonomy, then it represents a wider issue than the clinical, and is not a matter defined by standard medical practice but rather one which is to be determined by reference to considerations which go far beyond the gap in technical skills and expertise between doctor and patient. Respect for persons demands that the opportunity for free decision-making is made available, and that the choice - albeit coupled with professional recommendation - is that of the individual who holds the right. The request for technical skills to be exercised, for example in a request for diagnosis, cannot and does not impose on the person making the request a duty to accept even clinically optimal recommendations.

Thus, if medicine is to be a good, it must do more than merely demonstrate through its practitioners a high level of technical skills. It must also contain and foster the moral element which protects the integrity of the individual. But this moral element goes beyond professional definition, and demands external considerations of a type which doctors, in common with other professionals, are not inevitably the best or most appropriate persons to judge. Moreover, it is here also that the significance of the medical enterprise can be seen to impose even greater responsibility. When communities delegate important decisions about health and illness to orthodox medicine, with the potential implications of diagnosis and treatment, then it is even more important that participation in the enterprise is both free and knowing. In this way, autonomy is respected.

Viewing medical intervention in this way makes analysis of the relationship between doctor and patient in the terms of human rights, intelligible. Admittedly some claims which patients may have in health care may not be capable of practical resolution, even if they can be couched in the language of rights. For example, difficulties may arise from the fact that the medical enterprise is itself circumscribed by resource problems. The fact that health care resources are unlikely ever to meet potential or actual demand may result in the denial of appropriate care in some cases. The shortage, for example, of dialysis equipment - a situation which evidently could be remedied - means that decisions must be made as to how resources are allocated.[66] However these decisions are made, they represent a lack of universality in health care, which renders the use of the language of rights rhetorical rather than likely to achieve practical results.

Equally, whilst the patient may reasonably feel him or herself to be entitled to the best possible care, or even to cure, it would be an unreasonable and intolerable burden to place on any discipline a demand that this was universally the actual result. However, the patient can legitimately demand a reasonable standard of care, and a perceived failure to supply care at this reasonable standard can, and sometimes does, form the basis of a grievance redressable at law.

Thus, although the language of rights may not always point a clear way for resolution of perceived problems, it nonetheless plays a significant part in the determination of the relevant interests at stake. In any event, the sane adult who enters into a relationship with medical practice will have two distinct sets of conscious or unconscious expectations. On the one hand, he or she may reasonably demand a level of care which is acceptable - not primarily as an aspect of human rights but rather as an aspect of what can be expected from a group setting itself up as having special skills, which skills are the basis of the patient's decision to seek out a doctor. On the other hand, however, the patient can expect that mere admission of illness does not affect his or her standing as a moral agent. In other words, just as involvement with a lawyer does not diminish the moral standing of the client neither does involvement with a doctor inevitably imply or justify any reduced standing in a human being.

At a national level, protection of autonomy is generally offered by means of the law recognising its significance and vindicating its existence as a legal and a moral right. Whether by formal or informal rules about due process, or the careful determination of rights and duties, it is the law which can deter the unwarranted assumption of authority, and provide the capacity to redress grievances. Indeed, the reponsibility for such protection is one which is, in theory at least, of major importance to the law. As Shultz [67]notes:

> Judges and legal scholars have long asserted the importance of patient autonomy in medical decision-making. Yet autonomy has never been reognized as a legally protectable interest. It has been vindicated only as a by-product of protection for two other interests - bodily security as protected by rules against unconsented contact, and bodily well-being as protected by rules governing professional competence. Neither bodily security nor bodily well-being, however, is an adequate surrogate; they do not coincide with autonomy. Nor is autonomy merely a formal issue. Decisionmaking by competent professionals does not provide an adequate

> substitute for patient choice. Injuries that arise from invasion of patients' interest in medical choice are both substantial and distinct.[68]

Moral autonomy is, albeit often without direct reference, protected by most advanced legal systems. In situations where individuals are denied autonomy through, for example, the removal or refusal of valued political rights, or unwarranted denial of liberty, it is not merely the instant symptoms which are the source of outrage. Rather the fundamental concern is the denial of autonomous and self-determining status to the individual, of which the action under consideration is symptomatic, striking as it does at common morality and the consensus of what it is to be accorded the respect which the status of being human demands. Although seldom put into words in courts of law, at least in the United Kingdom, the concept of respect for autonomy is as much a matter of concern as the concept, for example, of due process - again not technically a concept of Scots or English Law, but nonetheless one to which significance is attached.

However, law is not merely concerned with narrow technicalities. Not only do laws develop to protect the individual, but the determination of breach of these laws is more wide-ranging than the mere assessment of technicalities. Whether it is the rights and duties of a civil servant or the rights of the newborn, law and its decision-makers are creative. Constant concern is demonstrated for the rights of individuals both as an aspect of what a developed legal system regards as good, fair and proper, and in due deference to international commitments to respect for the individual. Thus, it makes real sense to emphasise basic human rights in all aspects of daily life. Indeed, as has been suggested above, in some aspects of that life consideration of the rights involved is more than just desirable - it can become absolutely essentially to the matter in hand. The significance of the political enterprise for example makes the use of rights terminology routine. 'The right to work', 'the right to take industrial action' are now common-place terminology, as are demands for industrial and political autonomy and equality of bargaining power.[69] Whether or not these 'rights' show all of the characteristics of what are called fundamental human rights, there is a perceived value in the symbolism of rights discourse, which serves to emphasise not merely the power of language, but also the conceptual importance of the individual.

The potential invasiveness of medicine, and its social and political potential, make it an area ripe for rights discourse. More importantly, the inevitable personal - in physical and mental terms - impact of any therapy or diagnosis places medical care in the forefront of concern for the individual. But rights are not merely protected by payment of lip service to the conceptual framework within which they play a part. Translation of rights into reality is also vital to their national, international and personal significance. For this translation, we generally turn to the law to provide both a statement of what rights are, and the machinery whereby infringement of rights can be remedied.

Thus, it does not suffice merely to say that, for example, patients have rights in their interaction with medicine, nor that doctors' duties flow from these rights. The willingness of the law to redress legitimate grievances, and the mechanisms available for such redress, are of equal, if not even greater, ultimate significance to the description and realisation of these rights. It would be insufficient, not to say disingenuous, for example, to say as a matter of policy that patients have a right to choose whether or not to undergo therapy, whilst at the same time demanding that the patient who feels him or herself to have been denied this choice proves this to an unacceptably high level. Equally it would be unacceptable were the burden of proof to be raised to the level of near or actual impossibility. Moreover, the action available to the disaffected patient may have a profound effect on his or her capacity to prove invasion of physical or mental integrity.

## Conclusions

It is evident, therefore, that the practice of medicine and the application of its techniques - preventive, diagnostic and therapeutic - is not a value-free enterprise. At one level, the content of the interaction between medicine and the individual is a technical one. But the application of clinical skills, whilst central to the interaction, is but one aspect of what is actually going on. Beyond this, and subsuming it, is the moral quality of the act which tranforms a mere clinical act into a 'good' medical act. Even ignoring the doubts which some commentators have expressed about the real benefits of orthodox medicine, and in particular the doubts about its actual impact on health,[70] the nature of the medical act has a significance of its own. This significant value is more than cure or alleviation of suffering - it is also a recognition of the fact that the individual must not be subordinated to the acquired skills of any single group in the community. Just as consensual politics is deemed to represent the best form of government, so consensual medicine is the best form of that discipline. Indeed, most doctors (and patients) would find little to argue with in such a statement. However, breaches of faith do occur, and it is here that the law has a major role to play. Whatever the motivation, however benign the exercise of professional paternalism, the important issue remains the right of the patient not to be the subject of involuntary or unauthorised intervention in his or her life.

This discussion therefore will concern itself with consideration of the value and meaning of consent to medical treatment, as being the clearest example of the need for information disclosure and sharing. The provision of a real consent - real, that is morally and legally - is the act of an informed and autonomous individual as, indeed, is the refusal of consent. The debate currently raging in the United States concerning the choice of patients to demand the discontinuation of treatment, is another clear example of the concern felt by many as to the extent to which the patient actually is in control of his or her health. As reported in the <u>Bouvia</u> case in the 'Los Angeles Times' of March 14th 1986, the rights of patients in making decisions about therapy are increasingly under legal scrutiny. 'People', it was said, 'have the right to refuse medical care.' This right, the converse of the right to consent to it, will depend on a variety of factors which transcend the illness and its clinical classification, and which relate to individual choices about the best personal course. In the case of consent, therefore, only full knowledge of the implications of accepting or rejecting therapy will place the patient in a position to make the (personally) appropriate choice about his or her future. This contention becomes less challengable when it is accepted that information sharing is not solely a clinical matter, but a matter which offers, or has the capacity to offer, free choice and respect for autonomy. Autonomy is defined as 'the power or right of self-government'.[71]

A patient has no less right to this than does the person who is not sick. Equally as medicine changes and becomes inherently more risky, as well as potentially more therapeutically valid, the patient's voluntary involvement in it plays an even more significant role in his or her capacity for autonomy.

It will be argued here, therefore, that information disclosure plays a central and fundamental role, both in the autonomy of the individual and in the morality of the medical enterprise. Moreover, it will be shown that only legal decision-making which distinguishes between the technical and the moral aspects of the medical act can adequately safeguard either of these important considerations, even although ideally the two should be inseparable in the practice of the physician. Particular attention will be paid to the mechanisms currently available for redressing grievances, since it is here that the actual commitment of the law to safeguarding patient autonomy can most clearly be seen. In this way, a theory of the role of consent at the abstract moral level will be tested against the actual performance of the law and legal systems. The legal systems under consideration will prodominantly be those of the United Kingdom and New Zealand, with some reference to the United States, since they provide a variety of legal models for redress. These systems will be tested in respect of their desire or capacity to place primary emphasis on the rights of patients to make uncoerced and knowing choices about the value of therapy to themselves as individuals. Analysis will also be made of the nature of the decision-making involved and the implications of the decisions taken.

It will be argued that the provision or withholding of consent is the right of the patient, and on this depends the morality of the medical act. Since consent plays a role in the civil law in general, it will also be shown that the adequacy of information to which the patient is given access necessarily affects the legal status of any intervention. Neither medicine nor the law are totally value-free enterprises, and it will be submitted further that there is, in the jurisdictions under consideration, and whatever the mechanism used, an apparent alliance between the law and the perceived good of medicine, which takes an overall rather than an individualised view of what medicine is about. Acceptance of the 'good' of medicine, may obfuscate the need for a 'good' medical act. Orthodox medicine it will be contended, is, however, the sum of its individual acts, rather than being some abstract, generalised good.

It will be accepted, however, that there are some situations where the apparently clear-cut demands for respect as an autonomous self-determining subject become more problematic. Children, the mentally handicapped and the mentally ill are the most obvious examples of this potential exception.[72] However, it will be maintained that a theory of consent which relates to individual human rights need not inevitably be inapplicable in these situations. In other words, the theory identified will be seen as the yardstick against which <u>all</u> medical acts should be judged. Thus, deviation from the level of disclosure and choice necessarily involved in this view of consent - whilst it may be possible - requires considerable justification.

In sum, it will be argued that the significance of consent provisions lies in their capacity to reflect and enhance the moral standing of the individual, and therefore that they have a collective impact on communities. The law has a major role to play in guiding professionals (including doctors) as to what is acceptable behaviour and what is not, whatever other professionals may believe, a necessary commitment to disinterested decision-making, and an interest in the provision of a viable method of redressing grievances. It will be assumed, therefore, that the law should reflect the rights of patients to give or withhold consent to medical treatment based on information disclosure, both through the form of action which it makes available and through judicial or quasi-judicial decision-making.

## NOTES

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Nuffield Provincial Hospitals Trust, 1976; Illich, I., Limits to Medicine. Medical Nemesis: The Expropriation of Health, Harmondsworth, Penguin, 1985 edition; Kennedy, I., The Unmasking of Medicine, London, George Allen & Unwin, 1981; Szasz, T., The Theology of Medicine, Oxford, O.U.P., 1979;

2. For discussion of the contemporary role of doctors, see Brazier, M.M., Medicine, Patients and the Law, Harmondsworth, Penguin, 1987, particularly at p. 5, where she notes 'Few professions stand so high in general public esteem as that of medicine....Yet few individuals attract greater public odium than the doctor or nurse who falls from the pedestal.'

3. Kass, L.R., Towards a More Natural Science, New York, Free Press, 1985; Currer, C. and Stacey, M. (eds), Concepts of Health, Illness and Disease, New York, Berg, 1986.; Klass, A., There's Gold in Them Thar Pills, Harmondsworth, Penguin, 1975; Melville, A. and Johnson, C., Cured to Death, London, Secker & Warburg, 1982.

4. Mohr, J. C., Abortion in America, New York, O.U.P., 1978.

5. For discussion of the role and standing of 'alternative' medicines, see, for example, Inglis, B., Natural Medicine, Fontana/Collins, 1979; Stanway, A., Alternative Medicine, A Guide to

Natural Therapies, Harmondsworth, Penguin, 1982.

6. for a critique of the role of pharmaceuticals in medicine, see Klass, op.cit.; Melville & Johnstone, op.cit.

7. Wood, C. (ed), The Influence of Litigation on Medical Practice, London, Academic Press, 1977.

8. for further discussion of a 'good' or 'right' or 'proper' medical act, see Pellegrino, E. and Thomasma, D., A Philosophical Basis of Medical Practice, Oxford, O.U.P., 1981.

9. op.cit.

10. c.f. Downie, R.S. and Calman, K.C., Healthy Respect, London, Faber and Faber, 1987; Downie, R.S. and Telfer, E., Respect for Persons, London, George Allen & Unwin, 1969; Downie, R.S. and Telfer, E., Caring and Curing, London, Methuen, 1980.

11. c.f. Declaration of Helsinki (1964), as amended by the 29th. World Medical Assembly, Helsinki (1975) and the 35th. World Medical Assembly, Venice (1983); see also, the Statement on the Rights of the Patient, adopted by the World Medical Association, Lisbon, 1981, clause c) of which reads 'The patient has the right to accept or refuse treatment after receiving adequate information.' For a full description of the various ethical codes governing the practice of medicine, see The Handbook of Medical Ethics,

London, B.M.A. (1984) pp.69-89.

12. for further discussion, see chapter 6, infra.

13. for further discussion, see Klass, op.cit.; Melville and Johnston, op.cit.

14. c.f. Brazier, op.cit., ix.

15. c.f., Inglis, op.cit.; Stanway, op.cit., p.15 et seq.

16. As Stanway, op.cit., says at p. 19, '...people are paying a high price for modern medicine and it's a price they may not have to pay. There is no one subject that disturbs people in the Western health care system more than the seemingly massive overuse of drugs.'; see also, Melville, D., Bitter Pills: Medicine and the Third World Poor, Oxford, Oxfam, 1982; Blum, et al. (eds), Pharmaceuticals and Health Policy, London, Croom Helm, 1981.

17. As Brazier, op.cit., says at p. 6, 'The medical marvels with which the public are bombarded reinforce the image of the doctor as superman. And so when a member of the public becomes a patient and 'superman' lets him down he is unsurprisingly aggrieved. Nor can doctors entirely blame the media for their image. Doctors decide on who get merit awards. Doctors vote with their feet as to which branch of medicine they enter. Many continue to vote for the glamorous world of 'high-tech' medicine.'

18. Shultz, M.M., 'From Informed Consent to Patient Choice: A New Protected Interest', 95 Yale Law Journal, 219, (1985), at p. 221.

19. c.f. Brewin, T., 'What to tell the cancer patient', Pulse, July 12 1980; Brewin, T., 'The Cancer Patient: communication and morale' 2 B.M.J. (Vol. 2) (1977) 1619.

20. Katz, J., The Silent World of Doctor and Patient, New York, Free Press, 1984.

21. For discussion, see Brazier, op.cit.; see also Dyer, C., 'In Pain? Sue the Doctor!' Law Magazine, 10 July, 1987.

22. McLean, S.A.M. and Maher, G., Medicine, Morals and the Law, Aldershot, Gower, 1983, reprinted 1985; Brazier, op.cit.

23. Muir v. Glasgow Corporation 1943 S.C. (H.L.) 3; the standard to be applied was discussed in R. v. Bateman (1925) 41 T.L.R. 557; for further discussion, see Gamble, A.J., 'Professional Liability' in McLean, S.A.M., (ed), Legal Issues in Medicine, Aldershot, Gower, 1981; Mason, J.K. and McCall Smith, R.A., Law and Medical Ethics, (2nd Ed.), London, Butterworth's, 1987.

24. for discussion, see Brazier, op.cit.; McLean and Maher, op.cit.; Mason and McCall Smith, op.cit.

25. for further discussion, see Currer and Stacey, op.cit.; Illich, op.cit.; see also, chapter 2 infra.

26. One of the most noted protagonists of this view is Szasz - for further discussion, see Szasz, op.cit.; see also, Hallek, S.L., Psychiatry and the Dilemmas of Crime, Berkeley, University of California Press, 1971.

27. see, chapter 4, infra

28. see chapters 4 and 5 infra

29. see chapter 6, infra

30. In particular, the capacity to withold consent has been much debated in the United States - see, for example, Satz v. Perlmutter 362 So. 2d. 160 (1978), aff'd 379 So. 2d. 359 (1980); In Re Conroy 98 N.J. 321, 486 A. 2d. 1209 (1985); Bouvia v. County of Riverside No. 159780 (Cal. Super. Ct. Dec., Dec. 16,. 1983); Andrews v. Ballard 498 F. Supp. 1038 (1980); In Re Quinlan 429 U.S. 922 (1976)

31. although the Royal Commission on Civil Liability and Compensation for Personal Injury (Pearson Commission) refers to them under the heading of 'insurance', Cmnd 7054/1978, paras 1316 and 1317.

32. Jandoo, R.S. and Harland, W.A., 'Legally Aided Blackmail' 134 N.L.J. 402 (1984)

33. for discussion of the negligence action, see Walker, D.M., The Law of Delict in Scotland, (2nd Ed., revised), Edinburgh, W. Green & Son Ltd., 1981; Weir, T., A Casebook on Tort, (5th Ed.), London, Sweet and Maxwell, 1983.

34. see chapter 3, infra

35. c.f., Lord Denning, 'The Freedom of the Individual Today' 45 Medico-Legal J. 49, at p. 59 where he said 'The medical people, the engineers, the chemists - all have their jargon which none of the rest of us understands.'

36. see, for example, chapters 2 and 6, infra

37. for description, see, e.g., Hall v. Brooklands Auto-Racing Club [1933] 1 K.B. 205, 224. As Lord Macmillan said in Muir v. Glasgow Corporation, supra cit, at p.10 'The standard of foresight of the reasonable man...eliminates the personal equation and is independent of the idiosyncracies of the particular person whose conduct is in question.' For further discussion of 'reasonableness' see Walker, D.M., op.cit.; Rogers, W.V.H., Winfield and Jolowicz on Tort, (12th Ed.), London, Sweet & Maxwell, 1984.

38. Lanphier v. Phipos (1838) 8 C. & P. 475; Hunter v. Hanley 1955 S.C. 200, per Lord President Clyde at p. 205 '"Reasonable care and skill" is...what is reasonable for a qualified member of that trade or profession...'

39. This being a decision for the court, see Walker, op.cit., p.201, 'The standard of reasonable care is not subjective....but objective, namely the standard of care which the court thinks a hypothetical standard individual, the reasonable

man, would display.' (emphasis added)

40. c.f., Gordon, G.H., 'The Expert Witness', in McLean, S.A.M., op.cit.

41. c.f. Roe v. Ministry of Health; Woolley v. Same [1954] 2 Q.B. 66.

42. for further discussion, see chapter 4, infra; see also, McLean, S.A.M., 'Negligence - A Dagger at the Doctor's Back?' in Robson, P. and Watchman, P. (eds), Justice, Lord Denning and the Constitution, Aldershot, Gower, 1981.

43. op.cit.

44. op.cit.

45. op.cit.

46. c.f. Hucks v. Cole 'The Times' 9 May 1968, where Lord Denning said that: 'A charge of professional negligence against a medical man was serious. it stood on a different footing to a charge of negligence against a driver of a motor car. The consequences were far more serious. It affected his professional status and reputation.'

47. c.f. Hatcher v. Black 'The Times' 2 July 1954; Roe v. Ministry of Health, supra cit.; see also, chapter 4, infra.

48. Hucks v. Cole, supra cit.; but see also Kilner Brown, J., in Ashcroft v. Mersey Regional Health Authority [1983] 2 All E.R. 245, particularly at p. 247.

49. Muir v. Glasgow Corporation, supra cit., per Lord

Macmillan at p. 10 'Those who engage in operations inherently dangerous must take precautions which are not required of persons engaged in the ordinary routine of daily life.'

50. for further discussion, see chapter 5, infra

51. per Lord Denning, in Roe v. Ministry of Health, supra cit., at p. 83.

52. supra cit.

53. for example, in the case of Canterbury v. Spence 464 F 2d. 772 (1972).

54. see, for example, discussion in chapters 5 and 6, infra

55. c.f. Gordon, loc.cit., at p. 209 'Where experts disagree, the court must choose between them.'

56. c.f. R. v. Matheson [1958] 1 W.L.R. 474; see also, R. v. Bailey [1961] Crim L.R. 828; Walton v. R. [1978] A.C. 788.

57. for discussion of this case and the nature of the treatment of psychiatric evidence, see Silverman, G., 'Psychiatry after Sutcliffe' (1981) 125 Sol. Jo. 518; Prins, H.A., 'Diminished Responsibility and the Sutcliffe Case: Legal, Psychiatric and Social Aspects (A "Layman's" View) (1983) 23 Med. Sci Law 17; see also, Mason and McCall Smith, op.cit., ch. 19.

58. R. v. Arthur 'The Times' 6 November 1981.

59. Leahy Taylor, J., The Doctor and Negligence, London, Pitman Medical, 1971 (at p. 1) 'It is no

disrespect to Her Majesty's judges to consider that their condemnation should disturb a doctor less than condemnation by his professional brethren.'

60. for discussion, see McLean, loc.cit.

61. c.f., Hatcher v. Black, supra cit.; see also, Lord Denning's discussion of appropriate decision making in medical cases in The Discipline of Law, London, Butterworths, 1979, esp. at p. 237.

62. for discussion, see Gordon, loc.cit.; The role of the expert is described by Lord President Cooper in Davie v. Magistrates of Edinburgh 1953 S.C. 34, at p. 40 'Their duty is to furnish the judge or jury with the necessary scientific criteria for testing the accuracy of their conclusions, so as to enable the judge or jury to form their own independent judgement by the application of these criteria to the facts proved in evidence.'; see also, Evidence of Opinion and Expert Evidence, Cmnd 4489/1970; Criminal Law Revision Committee, 11th. Report, Cmnd 4991/1972; Scottish Law Commission Memorandum No. 46: The Law of Evidence (1980).

63. for discussion, see, Harris, P., An Introduction to Law, (2nd Ed.), London, Weidenfeld & Nicolson, 1984. Harris says (at p. 49) 'A prime concern of any legal system is the protection of certain things (tangible or not) which are of value to

human beings. Not all these things can have the same value; nor can they always be given efficient protection against all invasions. A hierarchy is thus dictated by moral, economic and other considerations with the result that the law affords better protection to the better things in life.'

64. see also chapters 4 and 5, _infra_

65. Universal Declaration of Human Rights; European Convention on Human Rights.

66. for discussion of resource allocation, see Rescher, N., 'The Allocation of Exotic medical Lifesaving Therapy' (1969) _79_ _Ethics_ 173; Note 'Patient Selection for Artificial and Transplanted Organs' (1969) _82_ _Harvard Law Review_ 1322; Leenan, H.J.J., 'Selection of Patients' (1982) _8 J. Medical Ethics_ 33; Doyal, L., _The Political Economy of Health_, London, Pluto Press, 1979; see also, McLean and Maher, _op.cit._, chapter 10.

67. _loc.cit._

68. _ibid._ at p. 219

69. for further discussion of these types of claim, see Attwoooll, E., 'The Right to be a Member of a Trade Union', in Campbell, et al. (eds), _Human Rights: From Rhetoric to Reality_, Oxford, Basil Blackwell, 1986.

70. c.f. McKeown, _op.cit._; Illich, _op.cit._; Kennedy, _op.cit._

71. Chambers Twentieth Century Dictionary.

72. for further discussion, see chapter 8, <u>infra.</u>

## Chapter 2

Whilst many human rights have been created as a result of the abuse of individuals by states and their agencies and through forces which seem inherently wrong or dangerous in themselves, the use of the language of rights in respect of medical treatment is in a somewhat different tradition. It is used in this area rather to assess the result of the interaction of two forces both of which are deemed to be good in themselves - namely medicine and the law, as primarily represented by the judiciary. Moreover, the terminology of human rights is used both to protect the freedom of individual choice and to impose a corresponding duty on others to facilitate that knowing or meaningful choice through disclosure of information.

Whilst there is little doubt that choice-making about therapy is an aspect of the right to personal autonomy or self-determination, it merits specific consideration on a number of counts. First, it provides a classic example of the law's balancing of competing 'goods' and may therefore be instructive of the extent to which human rights may be limited or expanded by the law. Second, and to some extent derivatively from the first, health and health care are so fundamentally important to the human condition that the language of rightd may be used to ensure that technical interests are not given priority over the freedom of the individual patient to make choices based on disclosure - choices which could be technically (that is medically) irrational. A complication of this, however, is that the provision of health care through therapy may be seen as autonomy enhancing, rather than as a challenge to human rights. In some cases, for example the mentally ill and children, the decision to minimise certain aspects of autonomy by restricting information disclosure, may be seen as being protective of human rights, because, for example, of the existence of a right to treatment.[1] And, of course, the community attitude to health care may reflect ambivalence about the competition between the therapeutic imperative and the rights of the individual. Whilst not all communities have primary health care services which utilise orthodox medicine, every community has its medicine men. The rights which it is claimed patients have in the orthodox transaction are no less important in alternative forms of health care provision.

The practice of medicine has an ethical as well as a technical content.[2] The predominance in many cultures of high technology orthodox medicine in no way reduces the moral content and implications of the interaction between the doctor (healer) and the patient, although it may sometimes disguise it. That is, the growth of technology does not per se affect the essential nature of the medical transaction although it may change its form.

One feature of all medical transactions is the vulnerability of the patient, who lacks the technical skills on which reliance must be placed if he or she is to regain, or perhaps retain, the state of health which is so precious. Because of this reliance, the individual is highly dependent on obtaining the assistance of the skilled healer. One reason why health is so important to the individual is that on it rests not only freedom from physical and mental illness, but also the capacity to determine his or her current and future affairs. For these reasons, health has been equated with 'the degree of lived freedom'.[3] Further, health, and therefore treatment for ill-health, is more than a prerequisite of freedom or self-determination in life as a whole. It is also an area within which self-determination may be exercised. Indeed, given the importance of health to the individual, it is vital that he or she has the capacity and opportunity for decision-making in respect of medical intervention. This ability to make choices means that if the sick person is to retain autonomy, he or she must be free to seek treatment, to choose between therapies with different prognoses and even to choose illness over therapy. For where therapies carry risks which may be judged by the patient to be worse than the illness itself, or may produce side-effects of potential significance to the patient, there is no easily defined assessment of what, in these circumstances, actually amounts to 'health'. Health choices are part of life choices and cannot therefore be readily removed from the would-be autonomous individual. However, such choices may have to be made in situations where clear, long-term thought is difficult and the immediate pressures of illness coupled with the presence of skilled persons with superior medical knowledge may not be conducive to independent patient decision-making. Autonomy, therefore, is a crucial element of the medical transaction, but is not one which is always observed:

> Although the principle of individual autonomy is widely endorsed in theory, its practical implications for the doctor-patient relationship are controversial. Individuals exercise their autonomy in medical decisionmaking by arranging for needed professional services. Presumably these individuals remain the source of authority and can choose to delegate all or only part of their control to professionals. Yet, ironically, the most significant threat to patient autonomy comes from the very doctors whom patients hire. Because of their knowledge and traditional role, doctors often preempt patient authority.[4]

Nonetheless, the right to self-determination is one which communities and individuals treasure. As has been said:

> ...the assertion of civil rights in democratic countries has encouraged

> increasing interest in the rights of self-determination for every citizen and public participation in decisions which affect the general welfare. The democratic ideal has also challenged the claims of any group, professional or otherwise, to special privileges.[5]

Nowhere in the interaction between doctor and patient is the patient's fundamental right to self-determination more clearly expressed, or more contentious, than in the right to provide or withhold consent to therapy or other medical intervention, based on information disclosure.

The implications of this right are fundamental to an understanding of the human state, and form a vital part of the moral and legal status of medical practice. It is not merely that the choice between accepting and rejecting therapy, or particular forms of therapy, reflects the essentially voluntary nature of the medical enterprise, but also that the provision of adequate consent by the patient can render lawful actions which would otherwise amount to an assault.[6] The skills possessed by the doctor do not in themselves give him or her the right to make alterations to the physical or mental condition of another, and the need for real consent to be obtained provides a valuable protection for the autonomy of the patient.

If the major impact of the provision of consent by a patient is to render the actions of the doctor both moral and legal, and to protect individual rights, then at first sight it is difficult to see why any problems about this aspect of medical practice should arise. It would, in these terms, seem to be in the interests of both patient and doctor that real or true consent should be obtained. In the case of the patient, the right to retain physical and mental integrity is protected where he or she is genuinely in a position to make free and knowing choices about health care. The doctor protects him or herself legally in obtaining real consent, and should also find the professional relationship with the patient enhanced.

Nonetheless, problems do arise in this area, and challenges are made. For the doctor, such challenges, especially where litigation ensues, can be both personally painful and professionally damaging. For the patient, the desire or need to act in this way against a doctor may be both anxiety-provoking and expensive. At least in theory then, it is in the interests of both parties to any medical transaction that respect and trust are shown by each participant to the other. However, the way in which issues of consent are dealt with by courts and other relevant tribunals can, if viewed from the autonomy model, seem less than protective of individual rights.

The doctor/patient relationship is based, in its best manifestations, on trust. Often, however, this trust is perceived as a one-way transaction. That is, claims that trust is essential to a good and efficient doctor-patient relationship often seem to centre on the element of trust which the patient places in the doctor. If the patient demonstrates this trust, in addition to his or her essential dependence on the skills and expertise of medicine as a discipline, then it is assumed that the medical transaction has been successfully commenced, and may be satisfactorily concluded. However, trust may also - and more appropriately - be perceived as a two-way transaction. [7] That is, the doctor might equally be expected to trust the patient to cope with potentially distressing information and to take decisions about him or herself and his or her integrity, bodily or mental. It is in recognition of this latter element of a trust-based relationship that the provision of real consent becomes so vital, and yet it is precisely this element which may lead to many of the disagreements and disputes which make the actions of a given doctor the subject of challenge or litigation, since some medical practitioners are opposed to providing a full discussion of therapies and their alternatives in every case.

Consent is, in fact, both fundamental to, and highly problematic for, the doctor/patient relationship. The implications of insufficiently or improperly obtained consent are often vital to the general well-being of the patient and thus to the clinical, moral and legal aspects of medical practice. Consent is much more than a legal device or invention designed to intimidate medical practitioners. It is, of course, a concept adopted by national legal systems and by international agreements,[8] and is primarily derivative from a more general philosophical commitment to the essential right of the individual to make choices about what can and cannot be done with his or her body and mind. In other words, the legal system's insistence on the provision of consent in medical treatment is both a reflection and an acceptance of an agreed moral principle that the individual has a right to self-determination, which necessarily includes a right to physical and mental integrity.

Fundamental principles of this type may often be implicitly accepted rather than overtly stated. Nonetheless, their breach may result in general condemnation. For example, it is precisely the lack of respect for such principles which causes many people, including doctors, to condemn abuses of psychiatry wherever these occur, and the atrocities conducted in the name of medical science under the Nazi regime in Germany during the Second World War. Thus, where blatant abuses of the patient/victim occur, on grounds which are seen as malicious, political or spurious, condemnation of the perpetrators can be guaranteed. This condemnation is much more than just a reflection of the distaste which is invariably felt when medicine, as an essentially benevolent discipline, is used in such a way as to tarnish its commitment to caring and concern. It also reflects a generalised acceptance that nothing should be done to a person without that person's actual or real consent. That is, he or she should have the political or human right to participate or not, and the freedom to withhold cooperation - a freedom which is central to the right to self-determination and which is sadly lacking in the examples used above.

However, these examples are extreme, and as such tend to polarise opinion. Few have any real doubts about their reaction to the involuntary incarceration of those whose only apparent deviation from the norm is their expressed opposition to a political regime. Nor would many support the use of ethnic or religious minorities as guinea-pigs to be sacrificed on the altar of political dogma or scientific interest. The position, then, seems relatively clear. In these selected situations, people revolt against the exploitation of fellow human beings and, in so doing, recognise man's right to self-determination within medicine. This, then, seems to reflect a level of commitment to fellow citizens which renders disputes about the manifestation of their integrity through the provision of consent to medical teatment, obsolete.

The truth is, however, far from this. When situations are as clear as the alleged Soviet abuse of psychiatry, or the Nazi doctors' well-documented abuse of the Jews or the handicapped, then a powerful, vocal and fairly consistent response can safely be predicted. But the standard therapeutic medical interaction seems so far removed from these excesses that it appears at first sight to have no relationship whatever with them. Surely, there is no coercion, no political overtone in the ordinary practice of medicine?

Whilst this is an understandable question, there are those who for some time have identified just such characteristics even in the most elementary or apparently unproblematic medical action. Szasz,[9] for example, would argue that psychiatry always demonstrates just such features. Psychiatric diagnoses and treatments are, in his terms, political tools used to safeguard the community and its interests from those whose views or behaviour are unacceptable, strange or frightening. Illich,[10] further, argues that the role of medicine in the community is always, at least incidentally if not primarily, political, and he identifies several levels of political and functional deprivation[11] which can result from iatrogenesis (medicine induced illness) or from the aspirations and practices of medicine.

The picture, then, may be less clear than at first appears. Whilst the problems arising from the aims and functions of orthodox medicine may be overstated by Szasz and Illich, nonetheless, if health - physical and mental - really is vital to the human and political status of the individual, and through the individual to the community, then it is important that the moral principles on which the orthodox practice of medicine is based be carefully examined from the point of view of the human rights involved. In fact, the more subtle shades of the standard medical transaction do present examples of abuse which may be less clear-cut but which are nonetheless important, even although they may seem to have less overt political and moral import.

Of course, the subtle nature of the standard medical relationship makes the identification of abuse more difficult, and the fact that its motivation will generally be benevolent makes its exposure more painful. Nonetheless, such abuses as do occur may be every bit as detrimental to the good practice of medicine, in both its technical and moral sense. Requirements about consent are such that they are central to the moral nature of medical practice, as well as bearing on its technical and healing capabilities. The inevitable inequality of information and technical skills between doctor and patient, plus the essential vulnerability of the patient, make this requirement at once both highly sensitive and vitally important.

## How is Consent Evidenced?

For the patient to make a free and knowing decision either to consent to or refuse therapy, certain moral and legal requirements must be met. In theory at least these requirements seem to coincide. The patient should be a sane, adult person, free from duress, and the decision about therapy should be based on the provision of sufficient, intelligible information for him or her to make what is often referred to as an 'informed' choice. [12] As has been said, '[i]t is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.'[13]

Before considering what is actually meant by the real consent, it is appropriate first to consider how the patient may indicate consent to medical intervention, and as a corollary, how refusal of consent may be evidenced. It is sometimes thought that a patient evidences consent to medical treatment merely by consulting the doctor.[14] This inference is drawn from the mere fact of voluntary consultation, but a further step must be made before this consultation bears on the question of consent. Certainly, the patient will, in the run-of-the-mill medical transaction, freely and voluntarily consult the doctor, impliedly or explicitly inviting the making of a diagnosis, and perhaps even anticipating the prescription of therapy. Yet, can this really be equivalent to an acceptance of the subsequently recommended therapy without further information being given?

Quite apart from the obvious ethical considerations which would be involved were such an assertion to be routinely accepted, common sense would dictate that the invitation to exercise the professional expertise held by the doctor and to reach a diagnosis cannot be equivalent to providing consent to whatever treatment the doctor may then regard as being appropriate to the condition. Nor does it equate to consent to the use of potentially invasive diagnostic techniques unless these are explained and accepted. It may be that it is easier to equate the two when one considers the routine prescription of a drug whose side effects are likely to be known and minimal. However, if consultation equals consent to therapy then the same implications would also necessarily have to apply where the therapy was more radically intrusive, for example involving chemotherapy or amputation of limbs. Clearly, if consent is to mean anything, it must involve more than the mere fact of consultation. It must, in fact, be based on information, and since the patient knows little or nothing in advance about the likely diagnosis and the range of available therapies, he or she surely cannot have the decision to accept or reject that therapy pre-empted merely by taking the step of consulting a doctor. Consent,. in order to be meaningful, cannot be backdated to the stage at which the individual recognises illness and seeks investigation of its cause and nature. Further, in view of the rights which it has been claimed the patient has to make choices about whether or not to undergo treatment, it would be illogical to impute consent to therapy at a stage when the choice as to whether or not to accept it lies in the future.

Of course, the patient may come to the doctor specifically seeking a particular form of therapy, for example, anti-depressants or antibiotics. Indeed, such drugs may have been prescribed in the past. This situation differs from that descibed above in that there may already be an element of knowledge. The extent to which the situations differ will, however, depend on the extent of any prior knowledge which the patient had. Where the patient seeks a drug about whose risks and benefits he or she has not previously been informed, but, for example, requests it by specific name, it may be argued that this is an expressed or implied consent to accepting the drug, and therefore is real consent. However, if the nature of real consent is that it is based on information disclosure, then clearly mere knowledge of a brand name cannot constitute sufficient information to provide the patient with a knowledgeable choice of therapy. Further, were such a definition of consent acceptable, it would necessarily assume that consent is demonstrated simply by the patient saying 'yes' or taking the prescription, and would beg the fundamental question as to whether or not he or she can provide legally or morally acceptable consent in ignorance of risks and benefits.

This specific question will be considered later in more detail,[15] but it is worth bearing in mind at this stage that the doctor is consulted precisely because he or she has certain skills. The average patient lacks this expertise. The doctor who equates consent to treatment with the request for diagnosis or for the provision of certain drugs, is placing him or herself in a morally and professionally dubious position. Therefore, acceptance of therapy, whilst it may pragmatically seem to be the equivalent of actual consent to therapy, cannot necessarily be equated with a morally or legally acceptable or valid consent. This is an important consideration for doctors to bear in mind since, if therapy provided on this basis causes unpleasant side-effects, they may find themselves successfully challenged on the basis that, even although diagnosis and therapy were both accurate and appropriate, the patient was not aware of, and did not accept, the risks which in fact occurred. In other words, the consent which is given must be much more than the mere acceptance of the doctor's treatment plan, it should also be knowing, that is, based on information.

The second situation, involving the patient seeking the provision of a drug which has been prescribed before, differs fundamentally from this example. Where the doctor has previously explained the potential risks and benefits of the drug or therapy, then recent legal opinion would suggest that no explicit subsequent reference to them is necessary.[16] However, when consent is viewed as involving discussion and disclosure of information, even previous prescription of the drug or practice of the therapy would not satisfy these requirements where no explanation was made at that time. The requirement about disclosure of information remains, even where the drug or therapy has been used before.

This is not to say, however, that non-verbally indicated consent cannot be valid. Where sufficient information has been disclosed and the patient accepts the therapy, for example the provision of a prescription, his or her consent may be demonstrated by the taking of the prescription to the chemist, acceptance of the drugs and commencing the treatment programme. Indeed, it is probably the case that the method of indicating consent to therapy is legally and morally irrelevant. What is vital is the basis on which that acceptance of therapy is made, that is, the extent, nature and sufficiency of the information on which the patient formulated his or her decision.

What is fundamental to the provision of consent, then, is the protection of the freedom of the individual to make choices, and therefore, what functionally makes consent valid is that aspect of it which is sometimes referred to as being knowledgeable. For obvious reasons, the doctor may be better protected by having the patient consent in writing, since this leaves evidence of an agreement having been reached.[17] However, this may still be challenged if the patient claims that something other than what was consented to was actually done, or challenges the quality of information disclosed. Thus, in <u>Devi</u> v. <u>West Midlands Regional Health Authority</u>[18]

although a woman had signed a consent form authorising abdominal surgery, she was awarded damages since she had not consented to the doctor carrying out a sterilisation while she was under the anaesthetic. Further, in Wells v. Surrey Area Health Authority,[19] even the fact that a consent form (to a sterilisation) had been signed, was not taken as establishing in se that the information on which the signing was based was adequate. In fact, the court judged that the patient had been inadequately informed, and damages were awarded accordingly. Obviously, however, the more specific the consent form, the more likely the doctor is to be protected.

Consent, therefore, may be demonstrated in a number of ways, ranging from simple acceptance of the therapy, to the specific signing of a consent form. However, expression of a legally and morally valid consent, whichever of these devices is used, still depends on the informed[20] nature of that consent. It is particularly important to remember this, since it is the right of the patient to choose therapy or not - it is not the right of the doctor to treat merely because he or she can. Whilst it is easy to conceive of the doctor as having duties in respect of the patient, he or she has no rights in this respect, other than the right to practice his or her profession when authorised to do so by those seeking his or her help. This is a practical rather than a moral right, dependent on the professional requirements for entitlement to give treatment, rather than on any essential moral right to exercise his or her skills come what may.

## What is Consent?

Real consent is, in theory at least, a prerequisite of morally or legally valid medical practice, although English Courts have recently indicated that 'informed consent' is not a part of English Law.[21] Indeed, it will be argued infra [22] that there is much to be gained from using a terminology which differs from that of 'informed consent'. This is not, however, to imply that British courts will ignore consent as an issue, nor to imply that current legal doctrine has no implications about disclosure. As was said in Hills v. Potter[23]:

> ...it is quite clear from the English cases...that on any view English law does require the surgeon to supply to the patient information to enable the plaintiff to decide whether or not to undergo the operation.[24]

There is no doubt that Scottish courts would also give considerable weight to information disclosure, although the point has not been directly tested. As has been seen, the provision of consent is vital since it is not only a protection of the moral status of the individual patient but it also has the effect of rendering medical intervention lawful. For the patient, the former may be the more important aspect, but for the doctor perhaps the latter consideration is the more vital.

The valid provision of consent can turn what could otherwise be deemed an assault into legally protected behaviour. For, whilst consent is only rarely a defence in the criminal law, it may be a defence - as in this case - in allegations of a civil (that is non-criminal) nature. The reasons for this difference are illuminating. In the criminal law, it is not possible to change the nature of a charge, say, of murder because the victim consents to it.[25] Thus even voluntary euthanasia or assault remain criminal offences.[26] This is a reflection of the fact that the behaviour involved in the act is struck at by the law on the grounds that it is in itself morally reprehensible. Of course, this effectively limits some aspects of what might be called the autonomy of the individual who is not permitted to absolve the attacker of blame - even where he or she voluntarily submits to the assault - but this limitation can be justified because it represents only a small intrusion into autonomy and the overwhelming value of preventing such behaviour overrides the minimal value of this aspect of autonomy. The only situation in which consent will be a defence in the criminal law is where the lack of consent is central to the nature and quality of the act. Thus, for example, a reasonable belief that a woman consents to intercourse (not in itself a morally reprehensible act) will provide a defence against a charge of rape.[27]

Medical practice, however, is traditionally dealt with by the civil law, in terms of which acceptance of risk and agreement to take the consequences of the risk, should it occur, is a valid defence expressed in the maxim volenti non fit injuria.[28] In other words, the person who freely and knowingly agrees to a course of action which involves known risks is not injured legally if one of these risks actually occurs, and therefore cannot sue the other party to the enterprise if he or she is damaged as a result of the occurrence of the risk. So, although medical practice may involve the doctor in undertaking a course of behaviour which, in other circumstances, would be an assault - for example surgery - the knowing and free consent of the patient will render this lawful. Voluntary acceptance by the patient, based on adequate information disclosure, will also ensure that he or she cannot successfully sue the doctor should one of the risks to which attention was drawn, and which he or she indicated agreement to assume, actually occur. It is therefore in the interests of both doctor and patient that valid consent (involving disclosure of risks and benefits) is provided in all forms of therapy.

It has already been pointed out that mere apparent acceptance of therapy, whether verbally or in writing, is not necessarily a sufficient demonstration that consent has been validly given. Thus, even where the patient agrees to undertake the therapy, it cannot necessarily be assumed that this 'choice' has been based on sufficient information to render it meaningful or sufficient to satisfy moral or legal criteria. The provision of valid consent is much more than a mechanical procedure culminating in the patient accepting therapy. More is required, implying the disclosure of information, and perhaps even patient understanding of that information. [29] However, even this is rather vague and unhelpful. Disclosure of what? Does the doctor have a duty to ensure patient understanding? Need the doctor disclose rare and unlikely possible risks?

Clearly, if morally and legally valid consent is dependent on the patient being in a position to make a real choice, then there must be information made available to him or her on which this choice can be based. Of course, even without disclosure, it could be argued that the patient has available a sufficient range of choices. The patient may choose not to consult a doctor, or may accept or reject therapy without any information at all. Thus, if the right to self - determination is protected merely by the availability of choices, then does not the patient already have choices in these terms, and is self-determination not sufficiently protected by these freedoms alone?

The answer to these questions will obviously depend on what is meant by 'choice'. In the medical transaction, the freedom to consult a doctor or not does, of course, bear some relation to the freedom of the individual. Equally, the patient may choose not to seek any information about diagnosis or therapy, and it would be his or her right to do so. However, the patient who chooses the latter course of action will be increasingly rare in a rights conscious society, and the doctor should not assume that this will be the case. Equally, the fact that a patient has the freedom to consult a doctor or not, whilst it may be important, does not affect the freedoms and rights to which he or she may be entitled once the choice has been made to enter into a relationship with a doctor. In recognition of this, it is seldom argued that no information should be disclosed to patients about their proposed therapy, although it may be the case that, for example, in the routine prescription of common drugs, such as antibiotics, little if any information actually is disclosed by the doctor about possible side-effects. This is a reflection of a number of factors, such as assumptions about patient understanding of the likely side-effects of such common drugs, rather than a moral supposition by the doctor that there is no general obligation to make disclosure.

The major dilemma in questions of disclosure, however, relates more often to its nature and extent than it does to the actual need to make it. Thus, doctors may be uncertain about whether or not they are legally or morally obliged to make disclosure of risks even if a patient does not ask for information, and also about what sort of disclosure satisfies the concept of real consent.

Clearly, the doctor is the possessor of both skills and information in the medical transaction. Were it otherwise, then he or she would not be consulted. The patient, then, is vulnerable not only because he or she suspects illness and may therefore be in need of help, but also because of the inequality of information possessed by the parties in the doctor/patient relationship. If this information is essential to the ability to make informed choices in the vitally important matter of health, then the doctor has at least a moral duty to disclose such medical information as he or she has, even where this information is unsolicited. Indeed, to make the extent of disclosure dependent on the questions asked by the patient would obviously be inappropriate, since by definition, the patient is unlikely to possess the information which would be necessary to ensure that the right questions are asked. [30]

However, the doctor - whilst doubtless likely to accept the logic of this - is nonetheless still faced with the dilemma of what information must or should be disclosed in order to ensure that the patient is genuinely consenting. Does the patient have to know the technicalities of drug action or of the relevant surgical procedure? Should the doctor disclose all known risks, or merely some of them? How much account should the doctor take in deciding about the level of disclosure, of the chances of the therapy succeeding, even if its potential side-effects are particularly unpleasant?

One possible view, of course, is that only by making full and complete disclosure of all known risks and potential benefits can the patient's autonomy be protected. By selecting the information which is to be disclosed, the doctor is already limiting the patient's right to determine his or her own future, because certain assumptions are being made about which information the patient needs or should know. The desire of the doctor to be selective is easily understood, not only on the pragmatic basis that full disclosure could be unreasonably time-consuming, but also on the more general basis that the aim is to cure, or at least to alleviate, suffering, and that this could be said to be the most important aspect of the interaction of the doctor with his or her patient. Further, since disclosure of certain information might serve to dissuade the patient from undergoing the therapy which the doctor knows, or has reasonable grounds to believe, might ensure the improvement which the patient presumably sought when consulting the doctor, then surely the doctor has a professional duty not to disclose that information? In other words, if the patient voluntarily makes contact with the doctor, is it not reasonable that, where medicine can help, it should do so? Is the restoration of health not also vital to the patient's autonomy, perhaps as important as his right to make choices? Indeed, it may be that the restoration of individual health could also be seen as an important benefit to the community as a whole, either because of risks to the health of others, or on economic or other grounds.

Whilst this approach has certain attractions, it is based on challengeable assumptions. Most notable of these is the belief that voluntary consultation necessarily implies a commitment to cure or to undergo therapy. Further, and even more fundamentally, it seems to imply that the decision about whether or not to accept therapy is one which can or should be taken on the basis of purely medical considerations. It has already been claimed that mere consultation cannot amount to an indication of consent to therapy. For example, the patient may in fact only want diagnosis, and may not actually seek or accept therapy. Further, the patient may choose whether or not to undergo a given therapy on the basis of values and criteria which are not medical - they may be emotional, financial and so on. Only full disclosure of known risks and likely benefits will actually allow these other considerations and factors - which are relevant to the patient - to be taken into account. The role of the doctor is to facilitate health, not to inflict it on the public. Medicine has no general right to enforce its diagnostic techniques, therapies or palliatives on an unconsenting or unwilling patient. In some situations, of course, the health of the community may be deemed more important than the individual freedom to choose therapy or not. This is often the case in preventive measures, such as mass vaccination programmes. But it is worth noting that it was precisely because the patient in these situations is encouraged or required to undergo the vaccination that the Royal Commission on Civil Liability and Compensation for Personal Injury[31] (Pearson Commission) made damage resulting from vaccine a special case. Unusually in non-contract situations, compensation may be sought for vaccine damage under a strict liability scheme.[32]

In other situations, however, there is a close link between the unknowing and the unwilling patient. Few doctors, if any, would seriously countenance deliberately inflicting therapy on a patient who has refused to participate in it, even where the therapy is likely to succeed. Such behaviour could easily be seen as immoral and unprofessional, whatever its legal implications. However, medicine does seem to countenance undertaking therapy in respect of those who are not overtly unwilling - they may even have apparently consented - but who in fact have been denied the opportunity to be unwilling by the conscious withholding of information. This non-disclosure may be explained on the grounds that the therapy will be likely to be successful, but this may also be the case with the unwilling patient whose forcible treatment the doctor would be unlikely to seek to justify. The distinction between non-voluntary and involuntary medical treatment is a fine one. Thus, even where medicine knows it can cure, an elementary commitment to the patient's right to self-determination must allow for choice, and real choice is only available where disclosure is made.

Evidently, however, although full disclosure may be a morally attractive goal, it may be difficult to achieve for practical reasons. The extent to which these practical considerations are taken as significant will be evident from analysis of legal rules and attitudes, since they may have the effect either of reinforcing or reducing expectations, and will shape the practical definition of the rights of the patient.[33] The attitude adopted by the legal system will therefore play a fundamental part in the explanation of what is valid consent. In the meantime, however, there are further arguments beyond the purely practical one of time shortage which could be used in an attempt to justify limitation of information or even total non-disclosure.

For example, it may be argued that full disclosure of technical or specialised information is irrelevant and unnecessary because the patient cannot fully understand the information. However, the doctor may rationally be perceived as having a duty to make disclosure which - although it may ideally lead to or facilitate patient understanding - can also be seen as independent of it. That is, if the patient has a right to receive, and the doctor has a correlative duty to disclose, there is no inherent implication that the received information is also understood. Whilst some writers have argued that disclosure without understanding is useless,[34] it may be that the mere act of disclosing information and inviting discussion nonetheless serves a purpose which is important.[35] Thus, although disclosure of information which is highly technical in nature and which may be unintelligible to the patient may serve little, if any, practical purpose, it may nonetheless have an important symbolic one which may prove to be vital to the creation or maintenance of trust and respect between doctor and patient, and to the enhancing of the patient's autonomy.[36] In any event, whilst it seems reasonable to impose a duty to disclose, derivative from the patient's right to information, it is scarcely reasonable to impose a duty on the doctor to ensure understanding.

Further, whilst the patient cannot reasonably be expected to understand the technicalities of precisely how an incision is made or why a particular drug may cause nausea, hair loss and so on, it is disingenuous to pretend that he or she cannot understand the fundamental point that the result will be an abdominal scar, sickness or baldness. If information is presented in everyday language, then the salient points about side-effects can be grasped by most patients.[37]

It may also be argued that disclosure of risks will cause patient distress, and that therefore only selected (presumably non-distressing) side-effects should be disclosed. Indeed, it has been argued that disclosure of too many risks may amount to negligence if the patient is indeed distressed.[38] Buchanan,[39] amongst others, convincingly challenges this so-called 'prevention of harm' argument by pointing out its essential fallacies. First, a doctor will seldom be in a position to know precisely what will distress the patient, since that distress will inevitably be bound up with personal factors which may be totally non-medical. Secondly, for the doctor to act on the basis that withholding information will avoid patient distress, account must also be taken of the possibility that the withholding of information may in itself turn out to be even more distressing.[40]

This 'prevention of harm' argument further makes the (challengeable) assumption that the patient's distress about certain types of side-effect is irrelevant to the calculation as to whether or not to undergo therapy, whereas it may - on personal rather than purely medical grounds - be vital to that decision, and autonomy enhancing. It is also interesting to note the underlying paternalism of this view which, whilst it may in certain rare instances have some merit, is nonetheless a debateable basis for medical practice in general. Interestingly, the available evidence would suggest that many patients who are given full disclosure are not apparently harmed by it.[41] The implications of the approach which justifies non-disclosure seem to militate strongly in favour of the kind of one-way trust which reflects the dominance of the medical profession, and detracts from the benefits of a partnership between doctor and patient.

Whilst it is understandable that the doctor may have a bias in favour of therapy, or a particular therapeutic option, the mere fact that a potentially successful therapy is available should not blind him or her to patients' rights. Thus, it is unconvincing to argue against disclosure on the basis that it might prevent the patient from undergoing therapy. The patient may, as has been seen, on balance prefer the disease to the cure, or even the diagnostic procedures, for reasons which may be personally convincing but medically irrational. This apparent irrationality provides yet another argument against making full disclosure since, if the patient receives and understands the information what, it could be argued, is the point of taking the trouble to make disclosure if he or she can then ignore the import of it and act on a whim? It may seem particularly desirable to avoid irrational (in medical terms) behaviour in areas as fundamental as health and illness. However, it must be a part of the patient's autonomy that he or she can act on the basis of the information provided, or on the basis of different information. In other words, the patient may act on a mere whim or because other factors are more persuasive. It is, perhaps, only where the behaviour of the patient threatens others, that a justification for intervention is perceived, at least on classical utilitarian lines. The freedom to ignore professional or other advice is, of course, also a feature of other less sensitive areas of human conduct. Whilst A may freely and voluntarily consult a solicitor, who may advise him or her to the best of his or her ability to pursue course X, A may nonetheless choose to do Y instead. As in the medical situation, A will bear the consequences of his or her behaviour which may seem to be professionally irrational, but may in fact be personally sensible.

So, what, then, must or should a doctor disclose to his or her patient in order to ensure that real consent has actually been obtained? In this section, the emphasis has been on the moral and professional arguments about what constitutes reasonable or ethical consent. The final arbiter will, of course, be the legal system, since challenges which may reflect moral or professional convictions will - if redress is sought - be judged on the basis of tests set by the law, even if they are decided outside of a court of law. The extent of the disclosure required by the law will therefore be an important (although not necessarily satisfactory) guide to the doctor.

## The Legal Position

The civil law has the function of considering and balancing competing claims and interests. In this way it distributes loss by assessing the relative merits of behaviour. Overtly, therefore, the law could reasonably be expected to adopt a disinterested view of any professional behaviour, and to offer protection of fundamental rights such as the right to autonomy or self-determination. But is the situation this straightforward where the aims of medicine compete with the interests of the individual?

The interests of the community (as represented in this case by the law) may be reflected both by the protection of the individual's freedom of choice and by the protection of medicine and the availability of therapy. Balance, therefore, may be particularly difficult to achieve in this area. Courts have, indeed, perceived this situation as one requiring special precautions in order to ensure that an appropiate compromise may be attained.[42]

A number of theoretical positions have already been identified which could be used to justify anything from full to very limited disclosure of information. Since disclosure is fundamental to the extent to which consent can be said to be real, and therefore protective of individual rights, the amount of disclosure required by the law will be vital to the protection of such rights and the resolution of disputes.

The legal and the moral positions may not of course equate, even where they appear to be the same. The basic theoretical position is that consent is an essential prerequisite of lawful and morally justifiable medical intervention. Emphasis is therefore apparently placed on the rights of patients. As Pellegrino and Thomasma[43] point out:

> The traditional stance of benevolent authoritarianism in the patient-physician encounter is increasingly under scrutiny and challenge. More patients want full disclosure of the therapeutic alternatives. Legal opinion is unanimous in requiring informed consent not only in experimental procedures but in the ordinary therapeutic encounter.[44]

Whilst British courts have claimed to be prepared to reinforce the right of the individual to make choices about therapy, the extent to which they will actually do so seems to depend on considerations which relate to the type of intervention as much as to the rights of the patient.

In some cases courts have been prepared to uphold the patient's claim that real consent was not given and to award damages correspondingly. However, cases such as *Devi* v. *West Midland Regional Health Authority*[45] and *Wells* v. *Surrey Area Health Authority*,[46] where such decisions were taken, share a common characteristic which may help to explain the apparent willingness of the courts to provide redress. Each of these cases related to situations where the result of the intervention to which real consent had not been given was the sterilisation of the parties concerned. In one case, sterilisation was carried out during the course of another operation, as a means of avoiding the potential dangers of a subsequent pregnancy, and no mention had been made in advance that sterilisation might be carried out. In the other, although sterilisation had been discussed with, and agreed to by, the patient, it was decided that insufficient information had been given on which the patient could base her decision.

The common theme of these two cases may well be the fact that the implications of the surgery were so dramatic. It is claimed by some that there is a fundamental human right to reproduce,[47] and the courts may well have been heavily influenced by recognition of the existence of this right in reaching their decisions. They would, however, seem to be considerably less impressed by the claim that, no matter the nature of the proposed intervention, there is a fundamental human right to self-determination in medicine which is also worthy of legal protection, and which is best protected by requiring full disclosure of all available risks and benefits.[48]

The law does, of course, have a role to play in the rationalisation of competing interests. In cases where what is in dispute is whether or not consent has been validly given, the formal position of the law is that:

> It is clear law that in any context in which consent of the injured party is a defence to what would otherwise be a crime or a civil wrong, that consent must be real.[49]

This assertion would appear to reinforce the need for disclosure. However, although it seems to reflect an emphasis upon the rights of the patient to give real consent, this theoretical position seems to be at variance with at least some of the cases outlined above. The perceived necessity to rationalise the interests of the patient in making choices, and of medicine in curing or alleviating symptoms, seems in some cases at least to have induced the law to adopt views which can be described as paternalistic and which can also be effectively and convincingly challenged. The sane, adult human being may, then, be vulnerable to an apparent priority awarded to clinical decisions over the rights of the patient to make free decisions about what is to be done with or to his or her body or mind. The right to choose (however 'irrationally') seems to have been subordinated to the 'right' of the doctor to make disclosure or not, and to select what information will be passed on to the patient. Moreover, the selection of information on the basis of what are only arguably medical grounds, allows little or no scope for the kind of personalised choice which it has been claimed makes consent real, knowing and valid.

British, and other, courts have traditionally protected the clinical freedom of the doctor on those (relatively) rare occasions when a challenge to its exercise has been made.[50] The pattern of litigation in medical cases seems to have changed in recent years, however, and courts and defence organisations have been confronted with more regular challenges of this type. Whilst clinical freedom has been protected in most countries, it has been claimed that the British courts have been more protective than those in other countries, perhaps as a reflection of the general, prevailing attitude to medicine and its practitioners.[51] In other countries, a lesser commitment to the interests of medicine has resulted in a perhaps more genuine, but not necessarily more satisfactory, effort being made to reconcile the conflict between medicine and its patients. American courts, for example, have clearly stated that:

> A physician violates his duty to his patient and subjects himself to liability if he witholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment. Likewise the physician may not minimise the known dangers of a procedural operation in order to induce his patient's consent.[52]

This statement seems to identify no conflict of interest between the doctor's professionalism and the patient's rights. Further, whilst not excluding an element of discretion for the doctor, it nonetheless firmly restates the basic principle that the doctor's duty to disclose is based on the patient's right to receive information, although it still falls far short of a standard for full disclosure. In <u>Canterbury</u> v. <u>Spence</u>,[53] it was made quite clear that there were 'formidable obstacles to acceptance of the notion that the physician's obligation to disclose is either generated or limited by medical practice.'[54] The law, therefore, as representing the community, must, by implication, set standards for professionals and others which reflect the status accorded to the human being, and provide redress for infringement of his or her basic rights. However, in most jurisdictions full disclosure is not required - only that which is reasonable. The reasonableness question may hinge on what the reasonable doctor would disclose or what the reasonable patient could expect, but, whichever test is used, there remains an apparent assumption that not all information need be disclosed.[55]

It is argued that everyone, including doctors, is ultimately judged by the law. Legal standards are therefore necessarily vague, since lawyers can claim no specific expertise in many of the areas on which decisions must be made. Architects and engineers as well as doctors, will ultimately, in the event of challenge, find their behaviour judged by legal concepts and principles rather than by their fellow professionals. In this way, public accountability is said to be achieved, and the community has the benefit of continuity and consistency in decision-making. However, the law also serves a protective purpose both for the individual and for groups or professions. Thus, the abstract principle applied is of major importance, as is the way in which that principle is interpreted by the courts. Whilst both British and American courts, for example, would claim to espouse the same commitment to the individual's freedom, and the same appreciation of the difficulties of medical practice, nonetheless it will be seen that their practical approach has varied considerably, presumably because of the relative weight given to each of these factors when conflict occurs. [56] However, neither these nor other jurisdictions make a clear-cut commitment to the right of the patient to full disclosure leading to a meaningful, and morally reinforced, decision. Rather, there remains a bias in favour of clinical judgement. This so-called disinterested decision-making, then, may ultimately lead not to an acceptable standard, protecting the right of the patient to offer a meaningful consent (or to withhold consent), but rather to a reflection of the personal perceptions of judges or the interests of a particular group.

## How is Lack of Information Challenged?

The apparent legal commitment, in most jurisdictions, to seeing medical intervention as a profound good, coupled with an apparent distaste for legitimising challenges against medical decisions, is reflected in the cases referred to.[57] However, there has also been a further legal move which serves to make it more difficult successfully to raise an action against a doctor where the allegation concerns apparent or real failure to obtain genuine consent. This move is concerned with the methods available to the disaffected patient in seeking redress by way of compensation, and profoundly affects the capacity successfully to challenge breach of the right to consent.[58]

As a corollary, protection of valued rights and interests is offered through the existence of a system which can ensure redress in respect of those who are thought to have a genuine grievance. In recognition of the importance of autonomy in medicine, the right of the patient to make choices about the nature and extent of medical intervention is, therefore, in theory at least, legally protected, and compensation can be sought for the unauthorised invasion of what might broadly be called the privacy of the individual.

Traditionally, this right of action has been based on the concept that an unauthorised intervention is a form of (non-criminal) assault on the individual, an approach which has some apparent benefits for the patient, since it involves a straightforward commitment to the protection of his or her rights, and suggests that the right of action stems from a primary interest in protecting them. Simply, it depends on the patient's choices and freedoms. He or she need not have suffered measureable medical harm from the intervention but must simply have had his or her right to choose ignored, or his or her ability to make a choice seriously restricted by lack of information. The crucial element is that of non-disclosure, and the selection of information by the doctor could provide a sufficient basis for a successful action.[59]

However, recent trends have illustrated a tendency for this type of action not to be used.[60] Rather the courts are demanding that - except in the most extreme cases - the appropriate form of action would be in negligence and not on the basis of assault.[61] At first sight, this shift in the basis of the action may seem logical enough and relatively non-intrusive of the right to consent. After all, it may be said, what is essentially being considered is the behaviour of a given doctor, and such behaviour will normally be judged on the basis of what is good or normal medical practice, a type of assessment which is well suited to negligence analysis. Indeed, in one leading decision in New Zealand, it was expressly declared that, when dealing with matters of this sort, what is being considered is not the patient's rights but the doctor's duty. In Smith v. Auckland Hospital Board,[62] it was said that:

> If the issue in the case was the maintenance of the individual's right of self-determination, the matter would quickly resolve itself. But it is not. This is a question within the duty of care concept of negligence... The welfare of patients would not be secured if a doctor's duty to warn about proposed treatment was to be considered in abstraction from the condition to which they were to be applied.[63]

The emphasis on doctor's duties which is inherent in the negligence action could, of course, still protect individual rights if the doctor's duty is defined by law in appropriate terms.[64] However, courts have, rather, tended to emphasise the standard of care set by other medical practitioners as being descriptive of the doctor's duty.[65] Therefore the shift to the negligence action has, in most jurisdictions, provided limited opportunity for the individual to obtain redress for grievances of this sort and has served to redefine the right in issue. The alteration in the form of action which is deemed appropriate is more than merely symbolic, then. As has been noted:

> How the case is pleaded in many cases is more than a matter of mere academic interest. It will have important bearing on such matters as the incidence of the onus of proof, causation, the importance of expert medical evidence, the significance of medical judgement, proof of damage and, most important, of course, the substantive basis upon which liability may be found.[66]

Indeed, if the purpose of providing an action in such cases is the protection of individual rights, then, whereas the interpretation of others will be interesting and may be informative, to describe the right purely or even primarily in terms of the duty owed to the person who has the right seems to be to place the emphasis on an inappropriate aspect of the event. The description of the right seems to have a logical precedence over the description of the corresponding (and derivative) duty. It is clear that the assessments made under negligence analysis are appropriate when the crux of the issue is the professional behaviour of the doctor in terms of the exercise of his or her technical skills as diagnostician and healer. However, if requirements about consent are primarily designed to protect the patient's right of access to information and freedom to make decisions, then this technical behaviour is relevant here at a secondary, rather than a primary, level.[67]

## Conclusions

It has been argued in this chapter that there is a special reason for considering the rights of patients in medical treatment. Whilst such rights are clearly aspects of self-determination and personal autonomy, discussion of them demonstrates clearly how - even where there is a public commitment to protecting self-determination - competing 'goods' may be used insidiously to infringe on the core of the right itself.

To some extent, this hypothesis can be further tested by considering contemporary commitments - under international law - to the notion of self-determination.[68] This concept is not neutral in respect of medical practice, and indeed the language of rights has been used to delimit medical practice in some cases.[69] The international community has witnessed medical abuse in the past, resulting in mass outcry and the promulgation of codes rendering the unwarranted assumption of authority over the individual by doctors morally outlawed. The therapeutic imperative has, in international agreements at least, considerably less importance than the rights of the individual, although the translation of this moral position into the reality of individual protection is left to states whose processes and policies may not completely satisfy it.

Rights in medicine, therefore, play an important role in the general protection of the individual and the extent to which patients' rights are protected reflects the commitment of individual states to the autonomy of individual citizens. Whilst the ascription of a special status to orthodox (or alternative) medicine is not in itself unreasonable or threatening, if national legal systems ignore or obfuscate the narrow line between unwilling and non-consensual medicine, then the rights of the individual will receive scant attention in the face of the sometimes competing interests of medicine.

Having established that it is legitimate to talk in terms of a right to consent to medical treatment based on information disclosure, and briefly commented on some of the associated difficulties generated by the method by which such rights are protected, it is now pertinent to consider the role of the law in more detail. In particular, this demands concentration on the forms of action available to the patient, an analysis of the requirements which satisfy them, and the extent to which the available forms of redress are fundamentally committed to, or capable of, offering protection to the rights of the patient.

NOTES

1. For consideration of the 'right to treatment', see Campbell, T.D., 'The Rights of the Mentally Ill', in Campbell, T., Goldberg, D., McLean, S.A.M., and Mullen, T., Human Rights: From Rhetoric to Reality, Oxford, Basil Blackwell, 1976; see also chapter 8, infra.
2. For an excellent discussion of the importance of ethical considerations to the practice of medicine, see Pellegrino, E., and Thomasma, D., A Philosophical Basis of Medical Practice, Oxford, O.U.P., 1981
3. Illich, I., Limits to Medicine. Medical Nemesis: The Expropriation of Health, Harmondsworth, Penguin Books, 1985 edition, 244.
4. Shultz, M.M., 'From Informed Consent to Patient Choice: A New Protected Interest' 95 Yale Law Journal, (1985) 219, at p. 221.
5. Pellegrino and Thomasma, op.cit., at p. 159.
6. Thus, the medical situation differs from that under criminal law, perhaps because 'the injuries

are inflicted in such cases not for their own sake or in order to cause pain or gratify an intention to harm, but for the benefit of the patient.' - Gordon, G.H., The Criminal Law of Scotland, (2nd. Ed.), Edinburgh, W. Green & Son Ltd. (1978), at p. 828.

7. for discussion, see Calman, K.C. and McLean, S.A.M., 'Consent, Dissent, Cement' Vol. 29, No.4, Scottish Medical Journal, 209 (1984)

8. See, for example, the World Medical Association, International Code of Medical Ethics (Declaration of Geneva) 1947, as amended in 1968 in Sydney, Australia.

9. See, for example, Szasz, T., Law, Liberty and Psychiatry, London, Routledge & Kegan Paul, (1963).

10. op.cit.

11. Illich, op.cit. in chapter 2 identifies a number of levels of iatrogenisis; he speaks of social, political and clinical iatrogenesis, and says (at pp. 52-53): 'The issue of social iatrogenesis is often confused with the diagostic authority of the healer. To defuse the issue and to protect their reputation, some physicians insist on the obvious; namely, that medicine cannot be practised without the iatrogenic creation of disease....Disease takes its features from the physician who casts the actors into one of the available roles. To make people legitimately

sick is as implicit in the physician's power as the poisonous potential of the remedy that works.'

12. The use of the term 'informed consent' is a development peculiar to the United States. This terminology will not be adopted in this discussion for reasons outlined in chapter 5, *infra.*

13. *Canterbury* v. *Spence* 464 F. 2d 772. at p. 779

14. c.f. Mason, J.K. and McCall Smith, R.A., *Law and Medical Ethics*, (2nd Ed.), London, Butterworths, 1987, at p. 142, where they say '...consent may be either express or it may be implied, as it is when the patient presents himself to the doctor for examination and acquiesces in the suggetsed routine.' As is argued *infra*, mere acquiescence (without information) does not equate to real consent, although Mason and McCall Smith's view may seem to receive some support from the case of *Freeman* v. *Home Office* [1984] 1 All E.R. 1036.

15. see chapters 5 and 6, *infra.*

16. c.f. *Chatterton* v. *Gerson & Anor.* [1981] 1 All E.R. 257.

17. although it will not inevitably be taken as definitive of consent - c.f. *Wells* v. *Surrey Area Health Authority* 'The Times' 29 July 1978.

18. [1980] *7 Current Law* 44.

19. *supra cit.*

20. 'informed' here is taken to mean based on adequate disclosure of information.

21. Hills v. Potter [1983] 3 All E.R. 716; Sidaway v. Bethlem Royal Hospital Governors & Ors. [1984] 1 All E.R. 1018 (C.A.); [1985] 1 All E.R. 643 (H.L.)

22. see chapters 5 and 6, infra.

23. supra cit.

24. ibid, at p. 727.

25. See, for example, H.M.A. v. Rutherford 1947 J.C. 1; Rex v. Donovan [1934] 2 K.B. 498. For a full discussion of this point, see Glanville Williams, Textbook of Criminal Law, (2nd Ed.), London, Stevens & Sons, 1983; Gordon, op.cit.

26. As Williams op.cit. points out at p. 531 '...if a doctor, to speed his dying patient's passing, injects poison with the patient's consent, this will be murder...'

27. See, for example, D.P.P. v. Morgan [1976] A.C. 182; R v. Hatch [1980] Crim L.R. 651.

28. c.f. Walker, D.M., The Law of Delict in Scotland, (2nd. Ed., revised) Edinburgh, W. Green & Son Ltd., 1981, particularly pp. 496-7; see also, Rogers, W.V.H., Winfield and Jolowicz on Tort, (12th. Ed.), London, Sweet & Maxwell, 1984; for a succinct discussion of the implications of this doctrine, see Watson, A.A. and McLean, A.M., 'Consent to Treatment - A Shield or a Sword?' 25 Scott. Med. J., 113 (1980)

29. for further discussion, see chapters 5 and 6, infra.

30. see chapters 5 and 6, infra.

31. Cmnd 7054-1/1978

32. In terms of the Vaccine Damage Payments Act 1979. A system of strict liability differs from a negligence based action to the extent that proof of fault is not required. The claimant has only to show the link in causation between the event and the damage.

33. see chapter 9, infra. For consideration of the role of law in this area, see Harris, P., An Introduction to Law, London, Weidenfeld & Nicolson, 1984, at p. 216 '...the tort system and its capacity (and willingness) to provide compensation is just as much a reflection of social and economic developments in society as is any other area, institution or procedure of law.'

34. See, for example, the convincing arguments presented in G. Robertson, 'Informed Consent to Medical Treatment' 97 L.Q.R. 102 (1981).

35. see chapter 1, supra.

36. see chapter 1, supra.

37. for discussion, see Katz, J., The Silent World of Doctor and Patient, New York, Free Press, 1984.

38. M. Brazier, 'Informed Consent to Surgery', 19 Med. Sci & Law, 49 (1979).

39. A. Buchanan, 'Medical Paternalism', 7 Philosophy and Public Affairs, 370, (1978).

40. c.f. McLean, S.A.M. and McKay, A.J., 'Consent in

Medical Practice', in McLean, S.A.M. (ed), *Legal Issues in Medicine*, Aldershot, Gower, 1981.

41. See, for example, Pellegrino and Thomasma, *op.cit.*, at p. 214.

42. See, for example, the judgement of Lord Denning in *Roe* v. *Ministry of Health* [1954] 2 Q.B. 66, and discussion in chapters 4-6, *infra.*

43. *op.cit.*

44. *ibid.*, at p. 160.

45. *supra cit.*

46. *supra cit.*

47. c.f., Gordon, L., *Woman's Body, Woman's Right*, Harmondsworth, Penguin, 1979; McLean, S.A.M. 'The Right to Reproduce' in Campbell, *et al.*, *op.cit.*; see also the comments of the U.S. Supreme Court in *Skinner* v. *Oklahoma* 316 U.S. 535.

48. see chapters 5 and 6, *infra.*

49. *Chatterton* v. *Gerson & Anor.*, *supra cit.*, 264.

50. Indeed, Lord Denning, whose influence in medical cases cannot be underestimated, has made it clear that this protection is vital. For discussion, see Denning, *The Discipline of Law*, London, Butterworths, 1979; McLean, S.A.M., 'Negligence - A Dagger at the Doctor's Back?' in Robson, P., and Watchman, P., (eds.), *Justice, Lord Denning and the Constitution*, Aldershot, Gower Publishing Co. Ltd., 1981.

51. This is one of the assertions made in respect of

prescribing practices and the attitudes of tribunals such as the Committee on Safety of Medicines, in Klass, A., _There's Gold in Them Thar Pills_, Harmondsworth, Penguin Books, 1975: see also Illich, _op.cit._, chapter 2.

52. _Salgo_ v. _Leland Stanford etc., Board of Trustees_ 154 Cal. App. 2d 560 (1957), 578.

53. _supra cit._

54. at p. 781

55. see chapters 5 and 6, _infra._

56. see chapters 5 and 6, _infra._

57. see chapter 4, _infra._

58. for further analysis see chapters 3, 4 and 9, _infra._

59. The extent to which this is in fact the case will be discussed in chapters 5 and 6, _infra._

60. for further discussion, see chapter 4, _infra._

61. c.f. _Chatterton_ v. _Gerson_, _supra cit._; _Sidaway_, _supra cit._; _Canterbury_ v. _Spence_, _supra cit._

62. [1964] N.Z.L.R. 241.

63. _ibid._, at p. 247

64. for further discussion, see chapter 9, _infra._

65. _Sidaway_, _supra cit._; _Hatcher_ v. _Black_ 'The Times' 2 July 1954 (U.K.); _Reibl_ v. _Hughes_ 89 D.L.R. (3d) 112 (1978) (Canada); _Smith_ v. _Auckland Hospital Board_, _supra cit._, (New Zealand); _Canterbury_ v. _Spence_, _supra cit._ (U.S.A.)

66. Kelly v. Hazlett 75 D.L.R. (3d) 536 (1976) (Ontario High Court of Justice), 556.

67. see chapter 6, infra.

68. Although not referring expressly to self-determination, the rights which might be encompassed by this are clearly stated in the Universal Declaration of Human Rights (1948).

69. See, for example, World Medical Association, Declaration of Helsinki (1964 - revised 1975) (human experimentation).

# ASSAULT TO NEGLIGENCE

## CHAPTER 3

It has been claimed that the purpose of rules about consent is to protect the inviolability of the individual. By having the capacity to make free and knowing choices about whether or not to undertake a given therapy, or participate in a particular diagnostic technique, the individual's right to self-determination is protected and vindicated. Moreover, it has been noted that the form of action which is made available through the legal system is also a highly significant factor in the equation which leads to facilitation of the liberty of the individual. Indeed, the form of action available has significance on a number of counts. On the one hand, it dictates the nature and extent of the evidence necessary to sustain a claim successfully, and on the other - and perhaps more subtly - it reflects the hidden values ascribed to the interests which it is sought to protect.

It is axiomatic that, if the reason for maintaining the significance of the right to consent to medical treatment relates to patient autonomy and freedom from involuntary or nonvoluntary intervention, then the patient who is not provided with the opportunity to make free and knowing choices has been the victim of an invasion of his or her physical or mental integrity. In other words, whatever the motivation, the patient has been the subject of what could be termed an assault on his or her body or mind.

Although the terminology of assault, battery or trespass might at first sight seem more obviously linked to the criminal law, each of these concepts (which are used interchangeably here, although they are not, strictly speaking, synonymous[1]) has a relevant place in the civil law also.[2] Indeed, even in the medical act itself, not routinely an object of concern for the criminal law, as Skegg notes '[m]edical procedures which involve bodily touching come within the potential scope of the crime of battery (known more popularly as assault).'[3] Nonetheless, the use of assault-based terminology seems to some to be out of place in the medical situation which is essentially beneficent in motivation. Thus, it is clear that, for example, surgery would amount to a criminal (or tortious/delictual) assault were it undertaken in other circumstances, by different personnel and for different reasons. However, the act loses the taint of criminality (or tort/delict) when it is carried out for good reasons, with consent, by appropriately qualified professionals and in a proper setting.[4]

However, as far as the civil law is concerned, the act of surgical intervention need not be entirely value-free when it is conducted without the consent of the patient. This is the case because of the value which has long been attributed to self-determination as an aspect of what it is to be human. As John Stuart Mill put it:

> The sole end for which mankind are warranted in interfering with the liberty of action of any of their number, is self-protection ..... The only part of the conduct of anyone for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.[5]

Medicine - however well-intentioned - clearly has the potential to affect the sovereignty of the individual over his or her own body or mind when free consent is not obtained. As Shultz[6] said, in a more modern context:

> Ultimately....the stake of both experts and loved ones is less intense than that of the patient whose well-being is directly affected. Patients' preferences, therefore, ought generally to be controlling.'[7]

In other words, since the patient is the person most directly (albeit perhaps not exclusively) concerned by the illness, it is the patient who has the ultimate right to decide on the conduct of therapy - if any. Neither professional nor societal interest should, therefore, interfere with the right of the patient to determine his or her future in health care. Failure to respect these rights in the individual results in an action unsupported by the law. Notably, in medical matters the law involved will be that of the non-criminal system.[8]

Traditionally, and in particular before the synthesis of the negligence action in its present form, the action typically used to register complaint where such rights were not respected was based on assault. The trend in recent years however has been to move away from the assault-based action and into the negligence format.[9] There are a number of reasons for this shift in emphasis, and it is almost certainly not unconnected with the growth and development of the negligence action itself. However, there would also seem to be plausibility in the claim that it is regarded as many as inappropriate - perhaps even distasteful - to deal with medical matters in the terminology of assault, which conjures up deliberate or wilful threatening behaviour, or actual physical touching without consent. This shift has led to a move away from the perception of unconsented to therapy as an assault and may disguise the intention or recklessness lying behind the withholding of information. Indeed, it has in many jurisdictions, significantly affected the nature of decision-making and the underlying assumptions made by courts. As Shultz [10] notes:

> Discomfort with treating doctors under a doctrine aimed at antisocial conduct has prompted most jurisdictions to limit the battery action to those relatively unusual situations where a medical procedure has been

> carried out without <u>any</u> consent, rather than where the consent has been insufficiently informed. The modern allegation of battery typically arises when consent to a particular procedure is given and a different or additional procedure is carried out.[11]

Thus, as was indicated in the English case of <u>Chatterton</u> v. <u>Gerson</u>,[12] only a gross failure to inform and secure consent will result in a successful action in battery. Although this has never been tested in Scots law, it is likely, following the <u>obiter dicta</u> in <u>Sidaway</u> v. <u>Board of Governors, Bethlem Hospital</u>,[13] that Scottish courts would adopt a similar view.

However, this is not to say that the reasons for, or importance of, maintaining respect for the individual are different merely because the available action has changed. Although the nature of the legal action affects the quality of evidence necessary, the factors to be proved, and perhaps even the likelihood of success, the rationale for consent rules should not be forgotten. Thus, it has been said that:

> The relative infrequency with which battery claims arise today should not .... obscure the fact that battery doctrine retains a critical philosophical and practical function in protecting patient self-determination.' [14]

Whether or not the form of action is called battery, what is being protected - the interest under consideration - is the fundamental one of patient self-determination or autonomy. For this reason, the assault-based action was initially seen as appropriate since it not only offered obvious protection, but also symbolically was seen as an accurate description of what had in fact occurred when patient consent was deemed to be inadequate or absent. In fact, both its terminology and its form may seem to make it well suited to situations where it is alleged that therapy has been imposed without adequate consent - whatever its motivation. It establishes '.... an uncompromising base-line of protection for patients' self-determination.'[15]

This is achieved in a number of ways. On the one hand, it establishes the precedence to be given to patient choice without obfuscating the issue. Whatever the outcome, the patient is unequivocally given the right to make decisions about his or her own therapy and, where such rights are breached, the law provides a mechanism for redressing a legitimate grievance. Moreover, as the professionalisation of medicine developed, so too did the assumption of authority vested in the medical practitioner. Decision-making under the assault-based action reflected the rights of the individual rather than reinforcing the assumption of authority by the professional. The individual, in juxtaposition to respected professional decision-making, remained in a superior position. Thus, '[u]nder battery analysis, the patient's wishes take priority over even the fully competent recommendation of the doctor ....'.[16]

However, as has been noted, the current trend is away from overt protection of patient autonomy in even this symbolic way, and towards the casuistry of distinguishing between types of failure to inform. Although it is said that '[a] doctor who operates without the consent of his patient is, save in cases of emergency or mental disability, guilty of the civil wrong of trespass to the person .....'[17], it was made clear in Chatterton v. Gerson[18] and Hills v. Potter,[19] amongst other cases, that this refers only to cases where no consent has been given. The law, therefore, makes a distinction between a complete failure to inform and a mere withholding of information, however relevant or potentially of significance to the patient. Indeed, Lord Scarman in Sidaway[20] agreed that it would be 'deplorable'[21] to use the assault-based action in the vast majority of medical cases.

Equally, the development towards negligence and away from assault-based actions has also been evidenced in the United States.[22] Although trespass was accepted as the appropriate form of action in Salgo v. Leland Stanford Jr University Board of Trustees in 1957,[23] its routine use had been rejected even before the landmark decision in Canterbury v. Spence[24] by decisions such as Natanson v. Kline in 1960.[25] The benefits to the patient of the capacity to use the assault-based action were clearly perceived as being outweighed by the problems associated with it, and it is worth reviewing these benefits and drawbacks here, with particular reference to what has been claimed to be the fundamental interest underlying consent requirements.

## Benefits

The most obvious benefit of the use of assault rather than negligence has already been discussed - namely that the assault-based action gives priority both symbolically and in fact to the rights of patients to make free choices about therapy. In so doing, it underplays, and even undermines, the therapeutic imperative which is so often claimed to be a characteristic of medicine.[26] The mere fact that the relevant therapy is medically appropriate, is medically recommended and might result in cure, has less significance in this type of analysis than the fact that the patient must be free to choose whether or not any of these considerations is important or crucial. In this way, the patient's sovereignty over his or her body is protected and enhanced. At a moral level then, the use of the assault-based action seems appealing in offering sanctity to a fundamental good. The reasons for proceeding without appropriate consent do not enter into or confuse the equation, and the focus of attention remains the rights of the individual patient. Nor is this the sole benefit of the assault-based action from the patient's perspective.

Legal differences also exist between the assault and the negligence actions which provide an insight into further possible reasons for the shift in emphasis witnessed in most contemporary jurisdictions. If the rationale for consent rules is the protection of individual autonomy, then the mere fact that relevant information was not disclosed is sufficient to establish a cause of action. This is indeed the case under the assault action. However, and this will be discussed in more detail later,[27] there is a further requirement inherent in the negligence action which renders the right to self-determination of lesser significance. Using the framework of negligence requires evidence of one further - and often problematic - factor, namely that of causation.[28] In these situations, causation refers to the ultimate outcome of therapy. Thus, the patient must demonstrate that, had the information been disclosed, then the therapy would have been rejected. As Robertson says:

> The relevance of causation in informed consent cases is linked to the difference between trespass and negligence. If one adopts the view as the early American cases did, that failure by the doctor to disclose necessary information about the proposed treatment vitiates the apparent consent which the patient has given and thus gives rise to the tort of battery, the patient is not required to show that, had this information been given to him, he would have chosen not to undergo the treatment.[29]

Clearly, this difference may have a significant impact on the patient's capacity to have a grievance both recognised and redressed by the law.

It is human nature to assume that where something beneficial has occurred then the individual in question would have wished for it. Thus, where therapy has been successful, or at least has not caused significant deterioration, then it will - particularly given the value attached to medicine - be legally difficult for a patient to claim that he or she would not have undergone the therapy had the risk been disclosed. It is apparently as difficult for courts to conceptualise the patient who would have preferred to maintain his or her capacity for self-determination even in the face of potentially beneficial treatment, as it is for them to conceptualise the preference for death over life[30] - indeed, in some cases, the nature of the choice may be similar. Yet, as a self-determining human being, the patient is theoretically given the moral standing to make just such a decision. However, this moral standing, if unprotected by the law, retains an ever diminishing significance both legally and morally, whatever its importance may be in the abstract.

Analysis based on patient's rights, and not on the benefits - real or imagined - of therapy, not only permits the protection of patient choice, but also serves to place the court in a position to make factual rather than speculative decisions. In the assault-based action what is significant is the <u>fact</u> of whether or not information was disclosed, not its likely or possible impact on the person in question. Under negligence-based assessment, however, the court will weigh other factors also - such as, what would have been the rationality of having rejected therapy had the risks been known and what in fact was the outcome of the therapy. Whilst these factors would be irrelevant in the assault action, they can be, and often are, vital to the making of decisions under the negligence framework because of the form of the action itself.[31] They allow for the importation of value-laden criteria into what could otherwise be a merely factual conflict, and permit the admission by doctors that they have indeed failed to disclose certain information to go unchallenged and the patient unrecompensed. In other words, the patient's rights are submerged by the value placed on clinical judgements. As one writer puts it:

> .... if the claim is framed in trespass and the court concludes that the failure to disclose information was such as to vitiate the apparent consent given by the plaintiff, the legal wrong of which the patient complains is not the failure itself but rather the performance of medical treatment without consent .... Consequently, if the claim is framed in trespass, the patient is not required to show that he would not have consented to the treatment had the information been disclosed to him.[32]

From the moral perspective therefore, there are distinct practical, as well as abstract, advantages in the use of assault analysis. Given that the rules about consent were designed to protect precisely these interests, then it may seem surprising that the action does not continue to be legally sanctioned in routine cases. There are, however, a number of drawbacks to the use of the assault-based action which have served to support the shift towards negligence.

## Drawbacks

Perhaps the most significantly utilised objection to the sole use of the assault action, is that legally it might appear to require some form of touching,[33] which is, of course, not always the case in medical intervention. Without redefining touching to include, for example, the provision of drugs, it is difficult to see some forms of therapy as assault, since, in common-sense terms at least, they do not amount to touching. A reluctance so to redefine touching may have formed the basis of at least one aspect of the distaste for the use of the assault-based action in medical cases. Yet it need not have done so since other situations (equally requiring no touching) <u>are</u> legally recognised as redressible under assault analysis.[34] Thus, the law would not have been creating a special or unusual situation for the medical profession had it accepted that physical touching was not essential to the tort of battery or assault. If the interest to be protected is autonomy, then autonomy itself represents considerably more than mere bodily safety. In any event, even if this were the sole or the major prerequisite of autonomy, even then there need be no insurmountable obstacle to finding that an assault or a battery has taken place. Yet:

> Defining the scope of an autonomy interest in terms of physical contact with the body has intuitive appeal and offers a certain simplicity of administration. But ultimately, physical contact is too literal a demarcation for what is a much broader, non-tangible interest in patient choice. Health care choices of vast consequence can be made and implemented without such bodily contact as predictably triggers battery analysis.[35]

However, the question of 'touching' has been considered a significant drawback to the use of the assault-based action, and may have served to diminish its importance. Certainly, were the patient to be required to show that a 'touching' had taken place before an action in assault or battery could successfully be raised, then inevitably many patients would face grave, if not insurmountable, obstacles. However, the need to establish a 'touching' is not, on analysis, of paramount importance unless the concepts underlying assault are very narrowly defined or interpreted. Not only do other non-physical forms of assault have legal credibility, but if the interest which has been 'assaulted' is given priority, then it can scarcely be important how the invasion of integrity took place.

Indeed, physical touching, which is generally required in examination and so on, is not routinely regarded as an exceptionable aspect of medical treatment. It is, therefore, equally possible to argue that 'touching' in some cases may be the <u>least</u> offensive or invasive aspect of the medical act. If a doctrine is to be developed which covers both those situations involving touching and those which do not, then it must be - and generally is - developed from the interest which is considered worthy of protection. Thus, the actual mechanism whereby an interest has been invaded has less importance than the fact of its invasion. It has been said that:

> If the key issue is knowledge and choice regarding the fate of one's body, there is no meaningful difference between a decision that will be implemented by touching the body and one that will be implemented without doing so. Physical invasions have symbolic importance and they constitute one important class of situations in which autonomy interests are involved. To treat that sub-category as co-extensive with the autonomy interest as a whole, however, creates grave deficiencies in the protection of the broader interest.[36]

Thus, although the problems about the question of touching may seem substantial, the extent to which they have a real impact is dependent on whether or not the original function of rules about consent is regarded as being of prime importance. The problem, therefore, may be said to be pragmatic rather than fundamental. Indeed, were this to be portrayed as the fundamental reason for discarding assault, then the law could legitimately be accused of being disingenuous at best, and as having ignored the prime purpose of the law at worst.

An equally significant characteristic, however, of the move from assault to negligence - in fact, perhaps an even more important consideration - relates to the terminology of assault itself. This terminology is routinely reserved for deliberate or wilful anti-social behaviour - far removed, apparently, from the practice of medicine. Moreover the patient will normally have voluntarily placed him or herself in a position where the physician may reasonably expect to be invited to exercise his or her professional skills.[37] Apart from rather extreme examples, this will not normally be the case in what might be described as the 'standard' form of assault. Thus, the patient may be thought by some to have impliedly offered consent to whatever the doctor chooses.[38] Certainly, there is no doubt that - unlike other kinds of assault - even highly invasive surgery can be consented to. As Skegg says[39]:

> .... conduct which benefits bodily health should not be regarded as causing bodily harm. But even if it were regarded as causing bodily harm, there could be absolutely no doubt that it was possible to give a legally effective consent to such procedures.[40]

There is one further factor which distinguishes the doctor's behaviour from that which generally characterises assault. It is, of course, not necessary to have the actual intention to cause harm, nor even to act without the consent of a person, to sustain a criminal charge of assault or murder.[41] However, the benign motivation of medicine is perceived as distinguishing it from other categories of 'assault', whatever the impact on the patient. As has been said:

> Despite the capacity of the battery doctrine to protect the degree of physical autonomy in patients' relations with doctors, many aspects of the medical care relationship do not fit comfortably with the battery model. Doctors lack the anti-social motivation usually associated with intentional torts such as battery.[42]

This is doubtless true, but bearing in mind the fact that the distinction between unwillingness and lack of knowledge may be defined in a rather narrower way than is traditional,[43] there is at least little doubt that the withholding of information is both deliberate and conscious. The fact that it is designed to <u>benefit</u> and not to harm may have less significance than it is currently given.

Nonetheless, the factors outlined above have had considerable influence on the willingness of courts to countenance the use of assault-based actions in medical cases. But just how significant are they as reasons for the shift to negligence? It has been suggested that the problems identified with the question of touching are by no means insurmountable when it is borne in mind that it is the invasion itself, and not its method, which constitutes the assault, and threatens patients' rights. Moreover, whilst distaste for the terminology of assault in relation to medical practice is understandable, it is scarcely sufficiently weighty to merit the impact which, as will be seen later,[44] the shift from assault to negligence has had on protection of patient autonomy. In any event, mere terminological fastidiousness is seldom an acceptable or appropriate rationale for the rendering more difficult of the protection of a fundamental human interest. Yet, both of these considerations have been regarded as significant in the United Kingdom, as in the United States, in the move away from battery and towards negligence.

## The United Kingdom

There is no longer any doubt as to the appropriate action to be raised where the basis of the claim is an alleged failure to disclose risks of therapy. As Robertson says, '[t]he recent English cases have firmly rejected the view that failure to inform of inherent risks can vitiate consent and give rise to a successful action for battery.'[45] Scottish courts have had little opportunity to undertake consideration of these matters, but their practice seems likely to equate to that in England, since negligence is the predominant action for compensation in both jurisdictions and some of the leading cases decided by the House of Lords have originated in Scotland.[46]

The position was apparently finally settled by the House of Lords in the case of Sidaway,[47] although Brazier[48] claims that the debate about consent requirements in general is by no means over.[49] Whatever the interpretation of its impact on consent requirements, however, it does seem to settle the law in respect of the nature of the appropriate action. Even if Scottish courts had contemplated the retention of assault analysis, this decision would most likely effectively close this avenue in Scots, as in English, law.

This move in fact resulted from a acceptance of a combination of a number of the factors outlined above, even although they can be said to be of insufficient weight to merit a minimisation of the importance of individual autonomy. But it is also likely that the general growth of the importance of the negligence action in the redressing of grievances also played a part. Moreover, the courts' choice to concentrate on the duty to inform of risks, as if it had some kind of precedence over the right of the patient to receive information, has led to the claim that it 'would be very much against the interests of justice if actions that are really based on a failure by the doctor to perform his duty to inform were pleaded in trespass.'[50] It would, however, equally not be against the interests of justice were priority given to the interest of the patient in maintaining his or her autonomy - a priority which is more evident in assault-based than negligence-based analysis.

In other words, the court in this case made a series of presuppositions and presented them as being important in serving the interests of justice. But no analysis was made of whether or not these presuppositions were 'right'. In particular, the assumption that the issue for concern is the doctor's duty fails to take sufficient account of the right from which that duty is derivative, and whose boundaries must shape the nature and extent of the duty itself. This last point will be considered in more depth later,[51] but for the moment it is worth noting the importance of the concept of duty in shaping judicial policy in these situations.

The decision in <u>Chatterton</u> v. <u>Gerson</u>[52] reflects the use of considerations of the type outlined above to reinforce the court's view that the assault-based action was inappropriate, even although - in terms of the rationale for the action - the problems of assault analysis may be semantic rather than fundamental. Nonetheless, they are given considerable weight. One commentator has suggested that these considerations - however open to challenge - were central to the almost universal drift to the negligence action, saying:

> It is submitted that there are two principal reasons for the judicial policy .... against trespass claims in informed consent

> litigation. First, ..... judicial policy seems to be in favour of restricting claims in battery to situations involving deliberate, hostile acts, a situation which most judges would regard as foreign to the doctor-patient relationship. Coupled with this is the stigma and damage to professional reputation which courts repeatedly emphasise are an inevitable by-product of a successful claim against the doctor. These consequences are probably seen as even more serious in an action for battery than in an action for negligence.[53]

Thus, the potential impact on the person whose behaviour is challenged of having his or her behaviour categorised as assault, here, as in other situations involving medicine, is given some consideration at the stage at which the decision is being made as to the very existence (or not) of the tort/delict, and the form of the tort/delict which has been committed. In other words, it could be said that the possible outcome of an action is taken as influencing the very basis of the claim itself.

However, if the above arguments are accepted, then these considerations might be thought to carry less weight than that which should be given to the potential impact of the action on the patient's right to self-determination. Yet the congruence of judicial policy making in this country is also reflected in other jurisdictions which have witnessed the same moves and justified them on the same basis. If for no other reason than this, they cannot be lightly dismissed. However, the aggrieved patient may find him or herself in direct conflict with such reasoning, however apparently widespread.

## The United States

Patients in the United States have routinely faced the same type of judicial reasoning as have their counterparts in the United Kingdom. As has been noted above, the assault-based action was decried for the same reasons in the United States as it was in the United Kingdom, and the shift to negligence is therefore vulnerable to the same criticisms. There has, however, been an occasional aberration from judicial solidarity in the U.S.A. which has most notably resulted from an apparent desire to provide some form of redress, even where the difficulties of using battery analysis are at their most acute. For example, in Mink v. University of Chicago,[54] whilst it was held not to have been negligent to have given pregnant women DES,[55] the court was clearly concerned to offer some avenue for redress, and therefore categorised non-disclosure as a form of battery, despite the absence of physical touching. The court claimed that '[t]he gravamen of the battery action is the plaintiff's lack of consent, not the form of touching.'[56] This case, whilst by no means the norm, nonetheless demonstrates that it is possible, even plausible, to ignore or avoid the problems associated with the use of the assault-based action in cases relating to the question of consent, where there is a will to safeguard patient choice and to provide compensation for a potentially far-reaching legal wrong.

'There was,' as Weir comments, 'bound to be a categorical conflict between negligence, with its insistence on unreasonable conduct and foreseeability of harm, and trespass, with its emphasis on positive action and directness of invasion.'[57] Seldom is this conflict more problematic than when the challenge is to a medical act - a situation where sympathy is often generated by both parties to the dispute.[58] In facing this dilemma, courts have apparently opted for what may be seen as a balance between conflicting evils. Indeed, it has been said that:

> The shift to negligence analysis made apparent analytic and practical sense. Although some critics decried losses to patient autonomy that would result from emerging negligence rules, current legal protection of patient autonomy has generally been deemed adequate.[59]

However, the same author continues, '[t]hat judgement .... rests upon assumptions that are insufficiently examined and ultimately erroneous.'[60] Indeed, it should be clear that the swamping of the tort/delict system by the rapid growth of the negligence action might, in some cases, have an adverse effect on precisely those characteristics of the system which other torts or delicts sought to protect. Assessment of the adequacy with which patient autonomy is protected cannot readily be made unless autonomy is the central characteristic against which success or failure is measured, yet this is not the basis of decision-making indulged in, or encouraged by, the current use of negligence in this area.

## Is Assault Analysis Enough?

The primary advantage, therefore, of the assault-based action would seem to be its direct responsiveness to, and concern for, patient autonomy. However, there are significant drawbacks to the action which are distingishable from the policy considerations outlined above. Whilst the assault-based action may have relevance, even in cases which do not overtly seem to concern 'touching', it cannot be a complete answer to some of the problems of real consent.

In some situations, for example, the patient's allegations regarding lack of consent may relate to the failure of the doctor to act rather than to an act itself. This is particularly likely where there is no disclosure of therapeutic alternatives. In this situation what is complained of - as in Hatcher v. Black[61] - is a lack of the kind of choice which is central to the provision of real or meaningful consent, rather than simply being a claim that information about risks and benefits was not given. Equally, analysis based on assault can be inappropriate where the event complained of is a failure to undertake certain diagnostic or therapeutic acts, as in Whiteford v. Hunter and Gleed.[62] This is not to say that battery analysis could not be used - rather that it could be said to have only a tenuous link with the common sense view of what happens in these situations.

Litigants in the United States have, however, occasionally been prepared to use battery analysis. In Gates v. Jensen,[63] for example, a doctor made a clinical decision that the patient's eye problems were associated with irritation from the use of contact lenses, rather than from a possible glaucoma. In the event, this was the wrong diagnosis, but the doctor did not choose to undertake the further tests which would have shown the glaucoma, and perhaps have prevented the subsequent blindness of the patient. The possibility of further tests was not mentioned to the patient since the doctor was apparently certain of his own diagnosis. Clearly, even although the patient's autonomy was threatened by non-disclosure of alternatives, this particular case could not suffice to satisfy even a modified version of assault analysis, because what the assault-based action protects in practice, although not necessarily in theory, is a form of physical safety rather than an interest in choice. As Shultz says:

> The choice of which Ms Gates was deprived - whether to undergo further testing for glaucoma - was certainly as important as the one she was given - whether to undergo treatment for the contact lens problem.

> Analyzed in terms of her interest in autonomy rather than her literal physical security, this patient's opportunity to adopt, reject or modify the doctor's unvocalized "recommendation" of inaction should have received as much protection as the choice about the contact lens treatment.[64]

However the use of the assault-based action in this case would, as presently interpreted, be entirely unsuited to vindicating the patient's rights. Again, in Karlsons v. Guerinot[65] a woman sued her doctor on the grounds, amongst others, that the doctor failed to perform amniocentesis. The plaintiff claimed that she had been denied the opportunity to provide informed consent because the doctor had not told her of its availability. The court held that the doctrine of informed consent was restricted to:

> ...those situations where the harm suffered arose from some affirmative violation of the patient's physical integrity such as surgical procedures, injections or invasive diagnostic test...[66]

and was, therefore. not appropriate in this case.

Thus, only certain interests will in practice be adequately protected by the assault-based action. Its extension beyond these areas would apparently stretch judicial credibility, in particular when emphasis is firmly placed on the question of physical integrity or security. Autonomy interests are, however, wider than the purely physical, and involve the capacity and freedom to make relevant and appropriate personal decisions.

It should be made clear that it is not intended to suggest that the freedom to make choices implies anything about patient knowledge or medical expertise. These choices depend on personal matters and not on technical information. Thus, it is not necessary that the patient should share the technical expertise of the physician. Those opposing patient choice, particularly in cases where therapeutic alternatives are not disclosed or diagnostic procedures are not undertaken, may seek to point to the technical gap between doctor and patient as a vindication of non-disclosure, given that the patient may make the 'wrong' choice. However, it can equally be claimed that the introduction of questions of technical competence, often undertaken by those who value clinical over personal decision-making, is a red herring which has been given too much credibility.[67]

To demand protection of patient autonomy through patient choice, is not to depend on the patient's technical knowledge (or, more likely, lack of it) but is rather to emphasise that it is the personal, even more than the technical, which makes for a good, meaningful choice, and that the patient is the sole person with the knowledge and skills to make such a choice. Whilst this may seem to be a face-on threat to medicine, it can also be seen as beneficial. The fact that diagnostic and therapeutic techniques are available need not blind physicians to their potential invasiveness. For this reason, as was indicated above,[68] the value of dialogue is substantial. Moreoever this assumes additional significance when it is borne in mind that a patient's interest in autonomy may equally be damaged by diagnostic failure or lack of information about therapeutic alternatives.

However, the position in both the United States and the United Kingdom remains somewhat removed from the goal of dialogue. As Shultz says:

> Protection of patient autonomy remains derivative rather than direct, episodic rather than systematic. As a result, significant harms to patient interests in choice go unredressed.'[69]

## Conclusions

This lack of protection stems from the powerful combination of medical prestige and legal reluctance to interpret available actions in such a way as to indicate or imply that there has been a deliberate invasion of the interests of the patient by the doctor. Moreover, even the assault-based action, which seems to offer some direct protection, has its limitations and pitfalls. Further, its use is also restricted since its success could result in the payment of damages where the therapy carried out was otherwise faultless. To the judiciary, and particularly in view of their fear of defensive medicine,[70] such a result would be both unfair and dangerous. From this perspective, the protection of patient autonomy could be seen as a threat to the practice of medicine, or at least as an interest whose value is subordinate to the overall value of the practice of medicine. Alternatively, the view might be taken that the values inherent in the medical act can be defined solely or substantially by reference to medical criteria. The apparent unfairness generated by the raising of a successful action where therapy is beneficial may be given more significance by courts of law than the fact that the performance of therapy without the patient's consent is objectionable in itself.

Moreoever, whilst the assault-based action may efficiently protect patient choice where there is a clear touching, it seems not to be able to achieve this either where there is no touching or where the invasion of patient autonomy results from a failure to disclose alternatives. These reasons, plus the policy ones mentioned earlier, have contributed to the shift to the negligence action. But has this shift resulted in more or less protection of autonomy interests? In considering this question, it is necessary to discuss the form and implications of the negligence action in general, before considering its specific application to medicine. In this way it can be ascertained whether it is true that:

> Existing legal protection for medical patients' autonomy is more limited than has been recognized and more deficient than should be tolerated. Present doctrines falsely equate protection of autonomy with

control over bodily contact. These doctrines also submerge analysis of the interests of autonomy with the related but divergent framework of redress for professional incompetence.[71]

## NOTES

1. In Scots Law, assault can be defined thus: 'Assault is an overt phsyical act intended to insult or affront or harm another, done without lawful justification or excuse. Assault is a real injury, tending to the disgrace of the person assaulted, and the worst kind of *injuria*, closely akin to defamation.' - see, Walker, D.M., *The Law of Delict in Scotland*, (2nd Ed., revised) Edinburgh, W. Green & Son Ltd., 1981, at p. 488.
In English Law, the definition differs, and the terminology of trespass is more common. For a discussion of the difference between assault, battery and trespass, see Rogers, W.V.H., *Winfield and Jolowicz on Tort*, (12th Ed.), London, Sweet & Maxwell, 1984, ch. 4 (p.53 *et seq.*)

2. For discussion of the extent to which the civil law continues to be concerned with the concept of assault, see Winfield and Jolowicz, *op.cit*; Walker, D.M., *op.cit.*, ch. 15, particularly at pp.488-498.

3. Skegg, P.D.G., Law, Ethics and Medicine, Oxford, O.U.P., 1984, at p. 32; see also, Skegg, P.D.G., 'Battery' [1974] Crim L.R. 693.

4. Thus, for example, it is clear that 'It is an assault for a medical practitioner to examine or treat a person unless that person, or the person's parents or guardian, has freely consented, expressly or by conduct, to the examination or treatment in question.' - Walker, op.cit., at p. 493.

5. Mill, J.S., 'On Liberty' 6 (1873)

6. Shultz, M.M., 'From Informed Consent to Patient Choice: A New Protected Interest', 95 Yale Law Journal, 219 (1985)

7. loc.cit., at p. 220

8. for discussion, see chapter 2, supra

9. For discussion, see McLean, S.A.M. and McKay, A.J., 'Consent in Medical Practice', in McLean, S.A.M. (ed), Legal Issues in Medicine, Aldershot, Gower, 1981; Brazier, M., Medicine, Patients and the Law, Harmondsworth, Penguin, 1987, esp. chapters 4 and 5; Robertson, G., 'Informed Consent to Medical Treatment' (1981) 97 L.Q.R. 102; see also, for example, Chatterton v. Gerson [1981] 1 All E.R. 257; Hills v. Potter [1983] 3 All E.R. 716; Sidaway v. Board of Governors, Bethlem Royal Hospital [1985] 1 All E.R. 643 (H.L.) In the United States, the position has

been the same, although the use of the battery action was sanctioned in <u>Salgo</u> v. <u>Leland Stanford Jr. University Board of Trustees</u> 154 Cal. App. 2d 560 (1957); but see, <u>Natanson</u> v. <u>Kline</u> 186 Kan. 393 (1960)

10. <u>loc.cit.</u>

11. p. 226

12. <u>supra cit.</u>

13. In particular, the view of Lord Scarman that it would be 'deplorable' to deal with such cases under assault rather than negligence at p. 650.

14. Shultz, <u>loc.cit.</u>, at p. 266

15. Shultz, <u>loc.cit.</u>, at p. 224

16. <u>id.</u>

17. per Lord Scarman in <u>Sidaway</u>, <u>supra cit.</u>, at p.649.

18. <u>supra cit.</u>

19. <u>supra cit.</u>

20. <u>supra cit.</u>

21. at p.650.

22. for discussion, see Robertson, <u>loc.cit.</u>; Shultz, <u>loc.cit.</u>

23. <u>supra cit.</u>

24. 464 F 2d 772 (1972)

25. <u>supra cit.</u> See also, for example, <u>Cobbs</u> v. <u>Grant</u> 8 Cal. 3d. 229 (1972).

26. for discussion, see chapters 1 and 2, <u>supra.</u>

27. see, chapter 4, <u>infra</u>

28. That is, the link between the doctor's act,

or ommission, and resulting legal harm.

29. loc.cit., at pp. 106-7

30. See, for example, McKay v. Essex Area Health Authority [1982] 2 All E.R. 771; Udale v. Bloomsbury Area Health Authority [1983] 2 All E.R. 522; Eyre v. Measday [1986] 1 All E.R. 488; Emeh v. Kensington & Chelsea & Westminster Area Health Authority [1984] 3 All E.R. 1044; but see also Curlender v. Bio-Science Laboratories 165 Cal Rep. 47 (1980); Turpin v. Sortini 182 Cal Rep. 337 (1982); Gleitman v. Cosgrove 296 N Y S 2d 689 (1967). For discussion of wrongful life actions, see Liu, Athena N.C., 'Wrongful Life: Some of the Problems' (1987) Journal of Medical Ethics, 69; Symmons, C.R., 'Policy Factors in Actions for Wrongful Birth' (1987) M.L.R. 269.

31. for further discussion, see chapter 4, infra.

32. Robertson, loc.cit., at p. 107

33. For discussion of this problem, see Skegg, op.cit. See also, the United States decision in Mink v. University of Chicago 460 F Supp. 713 (N.D. Ill. 1978), where it was held that the provision of DES (Diethylstilboestrol) to pregnant women was not negligent, but the court - seeking to provide compensation nonetheless - categorised the physician's non-disclosure as a form of battery, saying, at p.717 'The gravamen of the battery action is the plaintiff's lack of consent,

not the form of touching.'

34. for discussion, see, Walker op.cit. at p. 490, 'It is not necessary that the pursuer be struck or caused any physical harm...'; see also, Street on Torts (7th. Ed.), London, Butterworth's, 1983, at pp.21-22; Winfield and Jolowicz on Tort, op.cit., at pp. 56-57.

35. Shultz, loc.cit., at pp. 229-230

36. ibid. at p. 232

37. for discussion, see chapter 2, supra.

38. for discussion, see chapter 2, supra; see also Mason, J.K. and McCall Smith, R.A., Law and Medical Ethics, (2nd Ed.), London, Butterworths, 1987.

39. op.cit.

40. at p. 35

41. for further discussion of this point, see chapter 2, supra

42. Shultz, loc.cit., at pp. 224-5

43. see chapter 2, supra

44. for further discussion, see chapters 4, 5 and 6, infra

45. loc.cit., at p. 123

46. for discussion of the unreported Scottish case of Craig v. Glasgow Victoria and Leverndale Hospitals Board of Management (1974), see Mason and McCall Smith, op.cit., at p. 144

47. supra cit.

48. op.cit.

49. see particularly chapter 4.

50. Chatterton v. Gerson, supra cit., at p.265.

51. see chapter 6, infra

52. supra cit.

53. Robertson, loc.cit., at pp. 123-4

54. supra cit.

55. The women in question were entered into a clincial trial, in which DES was tested for its capacity to avert spontaneous abortions. The possible side-effects of DES include the development of vaginal cancer in the daughters of women who ingest it during pregnancy - for discussion, see Klass, A., There's Gold in Them Thar Pills, Harmondsworth, Penguin, 1975.

56. at p. 717.

57. Weir, T., A Casebook on Tort, (5th. Ed.), London, Sweet & Maxwell, 1983.

58. Both sides in the dispute, may, if viewed in the abstract, generate sympathy. As Brazier, op.cit., notes (at pp. 53-4), '...as liability, and the patient's right to compensation, is dependent on a finding of fault, doctors naturally feel that a judgement against them is a body blow to their career and their reputation. Yet a moment's reflection will remind the reader of all the mistakes he has made in his own job. A solicitor overlooking a vital piece of advice in a

conference with a client can telephone the client and put things right when he has a chance to check what he has done. A carpenter can have a second go at fixing a door or a cupboard. An overworked, overstrained doctor may commit a momentary error which is irreversible. He is still a good doctor despite one mistake.'

59. Shultz, loc.cit., at p. 227.

60. id.

61. 'The Times' 2 July 1954.

62. (1950) 94 Sol. Jo. 758; see also, *Barnet v. Chelsea and Kensington Hospital Management Committee* [1969] 1 Q.B. 428.

63. 92 Wash. 2d. 246 (1979).

64. loc.cit., at p. 230.

65. 394 N.Y.S. 2d. 933 (1977).

66. ibid., at p. 939.

67. for discussion, see chapter 6, infra.

68. see chapter 1, supra.

69. loc.cit., at p. 299.

70. see chapters 1 and 2, supra.

71. Shultz, loc.cit., at pp. 298-9.

# NEGLIGENCE THE LAW AND THE DOCTOR

## CHAPTER 4

The negligence action in its current form is a relative newcomer to the range of legal resources. Negligence is a complex subject, and a full discussion is beyond the scope of this discussion. However, what follows seeks to identify its major characteristics with particular reference to those aspects which are relevant to the argument presented.[1] However, it has had a major impact in its short history. As Weir,[2] for example, says:

> It was barely fifty years ago that the tort of negligence was born, or synthesised, but it has thrived so mightily and grown so lusty that one could be forgiven for wondering whether there was room left for any other tort at all.[3]

For the purposes of this discussion, tort and delict (the Scottish equivalent) can be used relatively interchangably, although it must be borne in mind that there are both current and historical distinctions between them. Only where clear differences occur will the terminology be made specific.

The aim of the law of tort or delict is to redress legally recognised harms or losses,[4] and of particular significance in the case of negligence is the attribution of liability for fault.[5] It is on the basis of the assessment that someone was at fault that damages are awarded, not merely so that compensation can be provided to the victim of that fault, but also to ensure that it is paid by the person whose fault caused the harm. Thus, whether or not the negligence action is overtly penal in its nature, there is an element which does relate to punishing the wrongdoer, or at least to making him or her pay. The parties to the action are defined by the nature of their relationship to each other, the behaviour under question and the responsibility of one party for causing the loss or harm complained of. There may be many victims of one fault, and there may equally be a number of people whose fault renders them liable to be sued. A succinct description of the law of delict is given by Walker, who describes the social function of the law of delict as being:

> ...to give legal recognition and protection to certain valuable interests of the individual and of groups of individuals and corporate persons. Interests are those claims or demands or desires which human beings seek to satisfy, which the legal ordering of human relationships must take account of, and which are deemed by the law to be valuable, deserving of protection, and justifying retribution or compensation if interfered with.[6]

The aim of compensation, is of course, also to offer something to the victim - generally this is expressed as an attempt to place the victim in the position he or she would have been in but for the fault of the defender,[7] and as the Royal Commission on Civil Liability and Compensation for Personal Injury (Pearson Commission)[8] noted:

> There is an elementary justice in the principle of the tort action that he who has by his fault injured his neighbour should make reparation. The concept of individual responsibility still has value.[9]

Of course, since the court is by and large limited to offering financial compensation, it can scarcely hope to achieve the desired result in cases other than those where the loss is solely pecuniary.[10] Nor is establishing the negligence of the defender merely a matter of overt common sense. The fact that someone has been damaged does not per se establish negligence, although it might raise preliminary presumptions about it.[11]

Because negligence is a legal concept, it is defined in legal terms. Thus, the basis on which damages can be awarded is tightly confined to certain types of action (or inaction) and to infringements of certain types of interests. In the United Kingdom jurisdictions, all torts and delicts have their own definition and structure, but basically they serve the same purpose - that of redressing wrongs and attributing responsibility for them. The balancing of competing interests and the distribution of loss in a just way are the raisons d'être of these branches of law. The law, therefore, seeks to protect certain interests, and where these are invaded, to compensate the victim.

But the law is not entirely value blind in making decisions on these matters since additional concerns may influence decision-making in regard to the nature of the interests which are seen to be under threat. There is, and perhaps must be, a hierarchy of interests deemed worthy of protection.[12] This has particular significance for the practice of medicine, and will be discussed in more detail below.[13]

Moreover, the rules of tort and delict also have a symbolic purpose. Although comment on these areas of law is not routinely couched in terms of human rights, essentially it is rights which are being protected when losses are distributed and claims are recognised as meritricious. The symbolic significance of this should not be underestimated, particularly in countries without written constitutions where the language of rights is less commonly used than in those countries which do couch civil obligations in terms of the rights to which they relate. From the right to liberty, for example, in the United States in particular, stem not only other rights (such as a woman's so-called privacy right to terminate a pregnancy in the first trimester [14]) but also the duty of others to respect that right and not to intrude, for example, by photographing private property or interfering in legitimate behaviour.[15] Equally, in the United

Kingdom jurisdictions, '[i]n addition to its more obvious function of redressing harms the law of tort also indicates rights: it has a constitutional as well as a compensatory function.'[16]

In some sense, therefore, the decision-makers - that is the judiciary - are also representing more than just disinterested law. As Walker says:

> It does not necessarily follow from the assertion of some right as a natural right or a human right, or as an individual or social interest, that the law will protect it and enforce legal rights and duties arising therefrom. Whether or not to recognise some interest is a policy decision for the law.[17]

The judiciary, therefore, also represent the state and give credence (or not) to the claims of citizens that they have a particular right or interest which is worthy of protection, as well as to the assessment of whether or not the right has been invaded. A creative judiciary, therefore, can have significant impact on the social order. Equally a judiciary loath to commit itself may seriously restrict the rights of citizens. This is true whether or not the remedy being sought is financial compensation or a declaration in the form of declarator or injunction. Personal liberty can be defined, delimited or destroyed by conservative decision-making or reinforced, expanded and vindicated by radical thinking.

The law of delict or tort is, therefore, wide-ranging and has broad concerns. Equally, the options available to decision-makers are not merely the provision of financial recompense.[18] However, in the case of the action in negligence, this is the sole option available,[19] beyond expression of judicial disfavour. The victim who raises an action in negligence may obtain personal satisfaction if the action is successful, but the court's role is restricted to making the legal assessment of whether or not the case is established, and, where the answer is in the affirmative, to awarding and calculating damages.

## The Negligence Action

Each member of the community is liable for his or her negligent or wilful invasion of the interests or rights of another, provided that the other was within the ambit of the duty not to invade that interest.[20] This is so whether there is a contractual relationship with the other party or not.[21] Social life demands obligations, breach of which renders us liable to moral and/or legal censure. Moral censure is perhaps the more wide-ranging of the two, since its attribution depends on a consensus as to the rightness or wrongness of behaviour. It is not hidebound by the rules of evidence, nor by the need to establish to a legal standard the harm caused, nor the legal quality of behaviour. The public, therefore, were in no doubt as to the moral culpability of the Distillers Company in the Thalidomide tragedy, although the law was evidently in a state of uncertainty as to whether the company was legally liable, and even as to whether or not the damage to the children concerned was a redressible wrong at law.[22] As has been noted, the mere fact of the harm is not a sufficient - although it is a necessary - element in establishing negligence. Thus, whilst public pressure resulted in ex gratia payments to the damaged children (or at least to some of them) there remained legal uncertainty as to whether or not the case would have been successful in a court of law.[23]

Indeed, the existence of a legal, as opposed to a factual, wrong is perhaps the most significant preliminary to the capacity of the individual to obtain compensation. The existence of that wrong depends on two main factors. First, that there is a party legally recognised to have been wronged and second, that the party causing the harm owed a duty to that person.[24] This may seem at first sight to be relatively uncomplicated, but to continue with the example of Thalidomide, it may not be so simple as it first appears. Many of the fundamental problems associated with the action contemplated on behalf of the Thalidomide children were concerned with precisely this point. Did the children have legal standing to sue, since they were not born at the time of the damage occurring? Few cases had considered this question - in fact, only one in Canada[25] and one in Australia.[26] Although this question is now resolved, its resolution depended in

Scotland on the use of Roman law principles, essentially based on a legal fiction,[27] and in England on legislation.[28]

Eventually, the question having been answered in the affirmative, the problem nonetheless remained as to whether or not there was a duty to take care in respect of this particular group. The law requires that care should be shown to those who might reasonably be foreseen as coming within the ambit of any such duty[29] but interpretations of this may vary. As the Pearson Commission said:

> In all cases, the law pays regard both to the degree of the risk and to the nature and extent of the damage or injury which might arise if the risk were to materialise. Both considerations are relevant to the question whether a duty of care arises, and to the extent of that duty.[30]

In the Thalidomide case, although the company specifically marketed the drug for pregnant women and therefore must have known that developing embryos would be involved, it equally, on the basis of state of the art experiments, did not perceive the drug as harmful.[31] On what 'reasonable' basis therefore could they be held to have knowingly generated the risk of the harm which subsequently eventuated?

Equally, it is necessary that the party who is alleged to have caused the harm can be sued for the occurrence of that harm.[32] The categories of negligence may never be closed,[33] but until recently there were some groups at least who were sheltered from its shadow. Most notably this arose in respect of lawyers themselves. In Swinfen v Lord Chelmsford,[34] liability for errors of fact or law was expressly precluded. However, this case arose before the modern development of the negligence action, and before expansion both of the heads of damage and of those who could be held liable.[35] Contemporary inclusion of lawyers demonstrates clearly the widening of the scope of the action itself, and reinforces the view that the judiciary can, and will, do more than merely operate within a rigid set of rules.

By expanding liability the judiciary also shape social rights. The development of the negligence action modified social policy and judicial decision-making reflected this. Moreover the role of the judiciary is significant in contemporary law also. The problems which arose in the Thalidomide case, however, are relatively rare and the person claiming to have been harmed as the result of another's actions will not necessarily have to face them. Given sufficient proximity,[36] the questions which will concern most plaintiffs or pursuers will be more intimately tied to the terminology of negligence itself. For negligence in general, these tests can be expressed thus: first, that there was a duty of care owed by the defender to the pursuer; second, that this duty was breached; and third, that the breach caused the harm complained of, which harm was reasonably foreseeable.

## Duty of Care

Perhaps the most significant (if now somewhat elderly) case on this point remains Donoghue v. Stevenson.[37] The facts of the case are well known and the radical nature of the court's decision-making well accepted. For the purposes of this discussion, the crucial aspects of the decision in this case were, first that the duty of care which the court held to be owed was one to take reasonable care to avoid foreseeable injury, and second that the judgement represented an expansion of the group who might be deemed to be foreseeable as likely to be injured by one's negligence.[38] Subsequent cases have used these principles to decide on the liability of, for example, subcontractors.[39] In combination with the later decisions in Hedley Byrne v. Heller [40] and Home Office v. Dorset Yacht Co. [41] a principle has been established which was described thus by Lord Wilberforce in Anns v. Merton London Borough.[42]

> The position has now been reached that in order to establish that a duty of care arises in a particular situation, it is not necessary to bring the facts of that situation within those of previous situations in which a duty of care has been held to exist. Rather the question has to be approached in two stages. First, one has to ask whether, as between the alleged wrongdoer and the person who has suffered damage, there is a sufficient relationship of proximity or

> neighbourhood such that, in the reasonable contemplation of the former, carelessness on his part may be likely to cause damage to the latter, in which case a prima facie duty of care arises. Secondly, if the first question is answered affirmatively, it is necessary to consider whether there are any considerations which ought to negative, or to reduce or limit the scope of the duty or the class of person to whom it is owed or the damages to which a breach of it may give rise.[43]

As Lord Bridge pointed out, moreover, in McLoughlin v. O'Brian:[44]

> A policy which is to be relied on to narrow the scope of the tortfeasor's duty must be justified by cogent and readily intelligible considerations, and must be capable of defining the appropriate limits of liability by reference to factors which are not purely arbitrary.[45]

Indeed, Lord Bridge considered not merely the legal culpability of the defendant in this case but also made the point that the attribution of legal responsibility for the psychiatric illness of the claimant would not be to impose a burden 'out of proportion to his moral responsibility.'[46] The remoteness of the damage might therefore be affected by considerations, not merely of a factual nature, but also of a moral nature. For example, despite a legal prohibition on trespassing, damages have been awarded to the trespasser on a railway line whose capacity to trespass was assisted by the failure of the Railways Board to maintain its fencing, and who therefore carried some moral blame for the incident.[47]

The assertion of the existence of a duty of care does not, of course, fully explain its content. As has been said:

> Given that a duty exists, it must be a duty with a content. The duty fixes not only the relationship between the parties but also the standard of behaviour to be required by the defendant.'[48]

The fact is, however, that it is in describing the duty of care that the parties to the action may come up against real difficulties and potentially irreconcileable positions. The fact that A might expect X does not necessarily mean that X is part of the duty owed to A - that will be decided by the law on the basis of what is 'reasonable', and what is 'reasonable' may vary. As Lord MacMillan said in Muir v. Glasgow Corporation:[49]

> The degree of care for the safety of others which the law requires human beings to observe in the conduct of their affairs varies according to the circumstances. There is no absolute standard, but it may be said generally that the degree of care required varies directly with the risk involved. Those who engage in operations inherently dangerous must take precautions which are not required of persons engaged in the ordinary routine of daily life.[50]

The nature of the duty may, therefore, vary with the inherent risks of the enterprise being undertaken. However, the ultimate test of behaviour, even in high risk situations, remains that of reasonableness in the given situation. Thus, as Lord MacMillan also said in the earlier case of Bourhill v. Young:[51]

> The duty to take care is the duty to avoid doing or omitting to do anything the doing or omitting to do which may have as its reasonable and probable consequence injury to others and the duty is owed to those to whom injury may reasonably and probably be anticipated if the duty is not observed.[52]

The duty of care, therefore, is not easily distintinguishable from its reasonably foreseeable consequences. Reasonablness is designed as an objective test. As has been said, '[i]t eliminates the personal equation and is independent of the idiosyncracies of the particular person whose conduct is in question.'[53]

Nor do the complexities of describing the duty of care owed stop there. The ordinary citizen is tested at the level of care which is deemed by the court to be that which ought to be shown by the 'reasonable man'.[54] However, the duty of care expected of others would normally be tested against what it would be reasonable to expect people in their situation to do, or conversely not to omit to do. Thus, those having or professing a level of skill beyond the norm must act in a manner which is reasonable, given that they are exercising that skill.[55]

This is not to say that the standard is necessarily higher, merely that it is different. One crucial difference is that, whereas the behaviour of the reasonable man is deemed to be within judicial knowledge, and experts may not be called to describe what is reasonable here,[56] the judgement of reasonable professional practice, is, as has been seen,[57] often substantially outside the scope of judicial knowledge and this routinely requires expert evidence as to the quality of the act or omission. Whereas it is not technically necessary,[58] expert testimony is generally used in such cases, as, for example, in the case of the doctor. Its formal status is no more than persuasive, although as will be argued below, in some cases at least, it appears to be taken as definitive of the case.

## Breach of Duty

Logically, breach of a duty of care can only be established where it is known or agreed that the behaviour in question is relevant to the particular duty of care. Thus, a surgeon who negligently runs over a patient with his or her car is liable to the patient in damages, but not *qua* surgeon. The specialised duty of care relates only to those aspects of life in which he or she is carrying out the professional role. Outside of that role he or she becomes the 'reasonable driver' and not the 'reasonable surgeon'. However, the question of breach of duty is, given that the duty has been defined, perhaps the least problematic aspect of the equation of negligence. It is a question of fact and will depend on the circumstances. However, the third aspect of the test for negligence, which is substantially connected to the question of breach of duty and the definition of the duty, is as problematic on occasion as is the first aspect.

## Damage Resulting from Breach

In some situations the logical link between damage and breach is so clear as to invoke the use of the doctrine of res ipsa loquitur.[59] Thus, in cases where the facts speak for themselves, there is no dispute about the liability of the defender to compensate his or her victim. In some medical cases, it is worth noting, however, that even where common sense might have suggested that the facts did indeed speak for themselves, the courts - for example in the case of Mahon v. Osborne [60] - were reluctant to apply the doctrine of res ipsa loquitur. In any event, it is relatively seldom that such clarity will be available to a court in reaching its decision. In McWilliams v. Sir William Arrol & Co. [61] it was said by Lord Reid that, '[a] pursuer must prove his case. He must prove that the fault of the defender caused, or contributed to, the danger which he has suffered.'[62] This is otherwise known as the question of proving causation. As Warrington, L.J. put it in Re Polemis:[63]

> The presence or absence of reasonable anticipation of damage determines the legal quality of the act as negligent or innocent. If it be thus determined to be negligent, then the question whether particular damages

> are recoverable depends only on the answer to the question whether they are the direct consequence of the act.[64]

Or, to put it another way, as Viscount Simonds did in the <u>Wagon Mound</u>:[65]

> It is a principle of civil liability ...... that a man must be considered to be responsible for the probable consequences of his act. To demand more of him is too harsh a rule, to demand less is to ignore that civilised order requires the observance of a minimum standard of behaviour.[66]

However, to couch this aspect of the test for negligence in these terms is to minimise the fact that causation may be more complex in certain areas of life. To return to the Thalidomide example, it is thought more than likely that, even if the law had been prepared to entertain the actions of the children, and even if, for example, Distillers could have been shown to have been negligent in some aspect of the production or marketing of their product, the link between the drug in question and the ultimate damage to children - that is the question of causation - might not have been capable of proof.[67] Cases of this sort require factual, often statistical, evidence of risk. Without this, then the link is tenuous (at least legally) if not, in fact, legally absent. It will not, therefore, suffice to show that, for example, the other children of the family are healthy, that there is no history of these specific defects in the family and so on, unless it can also be shown that sufficient examples of particular damage occurred amongst the children of the women taking the drug.

In this case, despite the 400 or so cases in the United Kingdom alone,[68] the element of causation between taking the drug and the ultimate harm to the children might have been difficult, if not impossible, to establish. Thalidomide was available in some 37 compounds in the United Kingdom, some available over the counter and some only on prescription.[69] A not unreasonable question in defence of Distillers might, therefore, have been why, if it was so widely available and so widely used, did not more cases of damage occur? Was the drug (legally) sufficiently linked to the damage to satisfy this last test? Some commentators feel certain that this last element of causation would not in all probability have been capable of proof to the level necessary in a court of law and the children would therefore have remained uncompensated.[70]

In particular, difficulties arise from the fact that causation may be problematic where it is (as may often be the case) not clear whether the harm (which can be factually demonstrated) is the result of the behaviour of a given doctor or merely a symptom of the pre-existing illness. A refinement of this problem exists when the therapy involves the prescription, and sometimes multiple use of, pharmaceutical products. As the Pearson Commission [71] were told by expert witnesses, the more that is discovered about the action of drugs, the less is actually known about their potential for harm, and the relatively common use of drugs in combination makes predictions as to likely effects increasingly difficult.

It can be seen, therefore, that there are numerous problems facing the pursuer in an allegation of negligence. The definition of negligence is tailored to what it hopes to achieve - that is the distribution of loss based on the fault of the defender. The imputation of fault must be carefully undertaken, since to hold people responsible lightly would itself amount to a social injustice as great as that which is said to arise when claims are rejected. The necessity of establishing the three-fold test for negligence is highlighted when one considers the possibility of the imposition of potentially unlimited liability on individuals, which would result were there no such rules.

Equally, the tests are demanding of the pursuer/plaintiff and in many cases the question as to whether or not there is a duty of care will not be capable of determination in advance of judicial pronouncement on the given facts.[72] Moreover, the extent and nature of the duty of care owed can in themselves be problematic, since they need not depend on a common sense view of appropriate duties. Essentially, in the routine case, the existence or not of a duty is a matter for legal determination, a determination which can, and sometimes does, depend on factors which lie beyond the purely legal.

In cases where the professional is challenged, policy considerations may be even more important and weighty. Liability can therefore be expanded or contracted by the importance given to factors which are not strictly relevant in the instant case. It has been suggested by some commentators that, whereas policy has recently served to expand the liability of many groups, the opposite is true in cases of alleged medical negligence.[73] Moreover, the causation element, which is difficult to establish in many situations, can be pragmatically more difficult in cases involving therapy.

Here too, there is also room for the use of policy considerations and extra-legal factors. As has been noted 'underneath the apparent factuality of causal vocabulary lurk value judgements.'[74] However, the law is designed to protect citizens and their basic rights, and seldom are these basic rights more vulnerable than in the maintenance or re-establishment of health.[75] If it is the case that the law protects important interests, and that health is among these, then one might anticipate that the highest possible standards would be demanded of those to whom such matters are entrusted - that is the medical profession. One method of offering this protection is, of course, by defining widely, rather than narrowly, the duty of care owed by the doctor to his or her patient. A duty designed to provide optimal care would offer redress in many cases, and the law - as the mechanism responsible for defining this duty of care - is competent to do just that. The next section will concentrate on describing the attitude which judges have taken to the duty of care owed by the doctor, and on translating the general tests for negligence into a medical context.

## Medical Negligence

The raising of an action in negligence by a patient against a doctor is the archetypal example of the frustration and hostility which can be generated by the failure of medicine to live up to the expectations of the patient. In other words, not all cases actually raised against doctors really are cases of negligence. They may rather be a reflection of the breakdown of relationships between doctors and patients.[76] Indeed, it is worth remembering that the impact of media coverage of medicine may also have a role to play in the generation of complaints. To some extent, both the medical profession and the media have conspired to generate an increased expectation of medical success, and perhaps even an exaggerated assessment of the competence of the average doctor. Thus, medical failure - whether or not legally actionable - may lead the patient into raising an action for damages.[77]

It is of course the case in medicine particularly that failure - whether from inherent risks or from careless or negligent therapy - may be particularly devastating for the individual patient. It is partly due to the esteem in which medicine has been traditionally held, and partly to the benign view which has been taken in general of the medical practitioner, that even the frustrated or non-cured patient has in the past been relatively unlikely to sue. However, it is also true that the low rate of action in such a risky enterprise as medicine has also - as with other professions - been related to the difficulties of obtaining the information necessary to raise an action,[78] or in finding a qualified expert witness prepared to state that a professional colleague was negligent.[79]

Some would suggest, however, that this situation has now changed. Reference has been made to the so called 'negligence explosion',[80] indicating that patients are now more than ever prepared to sue their doctors. Certainly, there is evidence world-wide that doctors are more likely to be sued than before where their diagnosis or treatment has been faulty or has failed.[81] In this, of course, doctors are not particularly unusual, since the twentieth century has witnessed a massive increase in talk of, and awareness of, individual rights. It has also been suggested, however, that the 'explosion' - such as it is - may relate to the breakdown of the traditional doctor-patient relationship,[82] in part due to the preponderance of group practices, clinics and so on. The family doctor, it is claimed, is now a more rare animal. Illich[83] amongst others would also suggest that medical training is such nowadays that doctors are reinforced in what Kennedy[84] calls the engineer/scientist model of medicine, rather than being the healers and friends they once were. In other words, as medicine becomes more technological, much of the doctor's training and expertise becomes focussed on high-technology apparatus, and is, resultingly, considerably less personal. This, according to some, has generated an ambience in which the (non-technical) malpractice of 'professional callousness' has become endemic.[85]

Of course, increased legal action against doctors has a number of possible implications and consequences. It may, for example, merely mean that the general increase in awareness of civil rights has produced a rise which equates to the number of cases which <u>should</u> have been raised in the past, but which were not raised. In other words, there may be no negligence explosion - merely, people's increased confidence in their rights as citizens may lead to perseverence and insistence on these rights in medicine, as in other areas. It may also be said that the increased number of actions against doctors reflects what has been suggested already - namely that the claims of medicine have placed patients in a situation of expecting miracles, and have correspondingly increased the legal vulnerability of the physician. Further, even despite current criticism,[86] the availability of legal aid may have played a part in facilitating litigation. Failure to achieve miracles may lead to frustration and hostility. Further, the increase in legal action - whether dealt with by defence organisations or courts - may have had an impact on the practice of medicine itself.

For example, it is often said - and there is good evidence to support this claim - that increasingly in the United States doctors are practising what is called 'defensive medicine'.[87] Indeed, in the United Kingdom, many judges - perhaps most notably Lord Denning - have used the fear of defensive medicine as a reason, or at least part of a reason, for not allowing claims in medical negligence.[88] The theory is that if claims against doctors routinely succeed, then the practice of medicine will become defensive, with the implication that the patient will suffer. Now this is open to question on two grounds.

First, it seems a rather cynical view of medical practitioners. If negligent practitioners are found to be negligent, then it is difficult to see the logic in the assumption that other (non-negligent) doctors will automatically shun treatments which involve any substantial risk, or play safe, or never attempt anything new. Second, it would seem to take the simplistic view that what is called defensive medicine is necessarily bad. Of course it is clear that defensive medicine - which is generally taken to mean excessive diagnostic zeal - may indeed be bad for patients. It is not only actual therapy which may place the patient in danger, but also some diagnostic techniques in themselves are dangerous. However, to assume that it is always bad to exhaust the possibilities before reaching a diagnosis and instituting therapy seems a somewhat overstated position. In The Influence of Litigation on Medical Practice [89] this view that defensive medicine need not be bad medicine is presented quite strongly by some of the legal contributors, and it is fair to say that it cannot be entirely discounted.

Defence organisations handle the bulk of the allegations made against doctors,[90] but the actual rules about negligence are contained in the decisions of the courts. Negligence is a legal, and not a medical, concept and is therefore subject to legal definition and explanation. However, it has sometimes been suggested that the settlements made by defence organisations will not always coincide with what amounts to legal negligence because they may be under other pressures to settle.[91] Equally, their role in filtering out cases is sometimes put forward as a reason for what some commentators claim is an overly cautious approach by the courts to those medical cases which eventually do come before them. Whilst it is not intended to consider the role of these organisations in any depth here, there are two points which require to be made on this subject.

First, on the question of perceived pressure on the defence organisations to settle, it should be noted that in this respect they do not differ significantly from Insurance Companies, who are also constantly in this kind of situation. In other words, to suggest that this has a major impact on the nature of cases which come to court may be to overestimate the importance of this pressure and to fail to place it in its proper context. On the second aspect of this point, it is certainly the case that, in real terms, the defence organisations <u>do</u> filter out a substantial number of cases, and will therefore have some impact on the success rate of cases which do go to court. For example, if they settle all cases of clear negligence, then the likelihood is that only those cases which they do not regard as negligent, that is which they feel capable of defending, will ultimately reach the courts. In this respect, the finding of the Pearson Commission that personal injury cases against doctors were considerably less successful than other personal injury cases,[92] may be partly explained. However, it is also worth noting that the defence organisations - whilst taking legal advice - will not unerringly be right in their assessment of what is negligent and therefore may choose to defend cases which do amount, in law, to negligence. In any event, in this situation also, there is very little difference between their role and that of Insurance Companies who routinely filter out clear-cut cases in other personal injury claims.

In considering questions of medical negligence, it is worth bearing in mind, as was pointed out by Lord Denning in the case of Hatcher v. Black,[93] that medicine does represent a significantly different type of enterprise from many others. As he said, in a factory if everything is done properly then everyone will be safe. However, he continued, in medical practice even if everything is done properly there remains an element of risk.[94] The doctor, by definition engaged in a high risk enterprise, would, one would expect, be subject to a higher standard of care because of this. Moreover, the potential impact on the patient of failed or negligently administered therapy is such that there is clearly a very significant interest to be protected by the law. One might expect, therefore, that the tests for negligence would be rigorously employed by the courts in medical cases and would be both clearly and unequivocally defined. In applying the tests of negligence specifically to the medical profession, it is intended to consider how each of the three necessary tests for establishing negligence can be, and are, applied in practice by courts of law. The information held on the files of medical defence organisations is maintained in secrecy, and is not therefore available for scrutiny, but, although their importance is not disputed, ultimately the test of a legal rather than a medical concept can appropriately be described by the attitudes adopted by courts.

## Negligence and Medical Practice

It will be remembered that the first aspect of the negligence action is the establishing of a duty of care between the doctor and the patient. This is a relatively simple aspect of the equation. The doctor's offer to treat is sufficient to establish a duty of care, whether or not the doctor is acting in a paid or unpaid capacity.[95] Indeed, even the provision of treatment in an emergency situation creates a duty of care, although the extent of the duty may be reduced or redefined according to the circumstances.[96] Thus, for example, the doctor who treats major injuries at the roadside cannot be expected to achieve the level of success, nor even perhaps the level of confidence, which he or she could do in a hospital with the appropriate environment and equipment. Nonetheless, negligence in the performance of what can reasonably be expected may still result in successful action. Indeed, it has been necessary in some American states, to pass what is called 'Good Samaritan' legislation in order to reduce the potential liability of doctors in these circumstances, since litigation had become so frequent and so successful that ultimately doctors refused to treat victims at the roadside.[97]

Whilst the duty of care owed by the doctor may arise either from contract or from delict/tort and indeed, may arise from both, the existence of the duty is seldom disputed.[98] However, this is not to say that problems have not arisen in the past, and in the United Kingdom they arose in particular before the establishment of the National Health Service, as to the nature of the duty owed by the doctor and, in particular, to whom this duty was owed. The issue of contractual liability was considered in the case of <u>Edgar</u> v. <u>Lamont</u>.[99]

In this case, Mrs. Edgar cut her finger and her husband called the doctor on her behalf the following day. Mrs. Edgar was under the doctor's care for a further two weeks, and ultimately claimed that due to his improper treatment she suffered great pain. Finally, her finger had to be amputated. Damages were claimed for pain, suffering and loss, as a result of the doctor's alleged failure to provide proper and professional treatment and attention. Dr.Lamont pleaded that Mrs. Edgar had no right to sue because, since the agreement was a contractual one, and it was her husband and not she who had entered into the contract, she had no standing in law. Lord Salvesen, however, said:

> It seems to me that the clear ground of action is that the doctor owes a duty to the patient whoever has called him in and whoever is liable for his bill, and it is for breach of that duty that he is liable, in other words that it is for negligence arising in the course of the employment, and not in respect of breach of contract with the employer.[100]

Thus, even in a situation when a contractual agreement arises - now less frequent[101] - it is clearly established that the doctor's duty arises in general from delictual/tortious, rather than contractual, duties even though the latter may be of fundamental importance in private medicine.

In the past, however, there have been further difficulties involved in the assessment of who is the appropriate person to sue. It is an important feature of negligence actions that the harm is redressible by the other. This involves establishing (a) who is entitled to sue, and (b) who is the appropriate person to sue. The first of these is relatively easily answered. In cases where the patient survives, then clearly if all the criteria are established he or she will have the right to sue personally. Negligence resulting in death can form the basis of a claim by surviving relatives on similar grounds to those which would have been available had the patient lived - in England in terms of the Law Reform (Miscellaneous Provisions) Act 1934 and the Fatal Accidents Act 1976, and in Scotland by the Damages (Scotland) Act 1976.

However, problems have arisen in the past over who is the appropriate person or body against whom the claim should be raised. In Hillyer v. St. Bartholomew's Hospital[102] in 1909 it was decided that a hospital was not responsible for the negligence of its employees. The reason for this hinged on complicated arguments about the nature of the contractual relationship between the doctor or nurse and the hospital. However, in 1951, the leading case of Cassidy v. The Ministry of Health,[103] made it clear that where a hospital is properly the employer, then it is responsible for the negligence of its staff. If, however, the patient employs the doctor privately, even if using the hospital's resources, the hospital is not responsible and the doctor is personally liable for his or her own negligence. The general practitioner is in a different position and must be sued personally if he or she is negligent,[104] whereas the hospital doctor will be pursued in conjunction with his or her employer.[105] Having thus established that the doctor owes a duty of care to his patient, whether or not there is an existing contractual agreement, and the question of who is the appropriate person to sue, it is necessary to consider the question of the extent of the duty of care and the problems of assessing whether or not the harm actually results from medical intervention.

Allegations of negligence in respect of the medical profession are intimately linked, if they are to be successful, to the nature of the doctor/patient relationship. As has been seen, this relationship is the trigger for a variety of duties on the part of the doctor. The doctor's duties, for example, may include a duty to maintain such information as the patient discloses in a confidential manner.[106] However, the commonest cause of legal conflict between doctor and patient relates to a perceived failure to exercise adequate professional care and skill, and it is this which most routinely forms the basis of actions in medical negligence. The risks of medical intervention are legion, some of them foreseeable and some of them less obviously so. Where the risks are unforeseeable, it is unlikely that their occurrence will give rise to a successful legal action. That this is the case was made very clear in the case of Roe v. Ministry of Health and Anor.; Woolley v. Same.[107]

In this case, two patients were operated on on the same day, both patients requiring minor spinal surgery. A spinal anaesthetic was administered in each case, given, in line with normal procedure, by lumbar puncture. A specialist anaesthetist, assisted by hospital staff, administered the lumbar puncture. The anaesthetic used was nupercaine, which was stored in sealed glass tubes kept in a solution of phenol to prevent the outside of the tube from becoming infected. This was a relatively new procedure instituted by the specialist in question, as a result of a number of cases in which the outside of the ampoule had become infected and caused damage to the patient when the hypodermic syringe came into contact with the tube. After the operations, both patients showed signs of spastic paraplegia caused by the phenol solution which had percolated into the anaesthetic through invisible hairline cracks in the sealed tubes. The outcome was that both patients were paralysed from the waist down, and both raised actions for damages. In finding for the defendant the court rejected the application of res ipsa loquitur, and further held that the hospital was not responsible in any case for the acts of the anaesthetist who had a private practice although he was also on contract to provide regular services for the hospital.

On appeal it was held that the anaesthetist was a servant or agent of the hospital, and that therefore the hospital was liable for his acts on the principle of respondeat superior. However, on the basis of the current established medical practice (that is current in 1947, when the accidents occurred) neither the anaesthetist nor any member of the hospital staff was in fact legally responsible for the damage. It was noted that, the court case being finally heard in 1954, information had subsequently come to light which suggested that the use of phenol to store anaesthetic ampoules was bad practice, but that, as this was not known at the time, the doctor's action in storing the anaesthetic in this solution of carbolic acid was undertaken in good faith. It was further suggested that the tube may have developed the crucial fault as a result of being carelessly handled by another member of the hospital staff, but Denning L.J. said, '[t]here is no duty of care owed to a person when you could not reasonably foresee that he might be injured by your conduct.'[108] In this case, Lord Denning also made one of his most often quoted and important statements. In discussing the question of liability in medicine he said:

> We should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong ....... We must insist on due care for the patient at every point but we must not condemn as negligent that which is only a misadventure.[109]

It is not, therefore, a sufficient basis for a successful legal action that the patient - rather than being cured - was actually harmed by his or her contact with medicine.

Lord Denning, moreover, continued to use this particular perception of the medical enterprise in a number of other cases. In the case of Hatcher v. Black[110] he further suggested that it would be wrong to suggest that, simply because a mishap occurred, doctors or hospitals should automatically be held to be guilty of negligence. No doctor, he said, should be found guilty because one of the risks attendant on an operation or other therapy actually did occur, or because in a matter of opinion he made an error of judgement. He further restated this attitude towards errors of judgement in the case of Whitehouse v. Jordan,[111] although his statement that an error of judgement is never negligence was ultimately specifically overruled by the House of Lords.[112]

According to Lord Denning, a doctor should only be found guilty if he has fallen short of the standard of reasonable medical care - an unexceptionable assertion.

However, he has also introduced other criteria to his decision-making in medical cases which go beyond the standard rule of law relating to reasonableness, and which seem to include extra-legal factors which may have considerable significance for the patient attempting successfully to sue.[113] For example, in the case of Hucks v. Cole,[114] he indicated that the burden of proof on the pursuer in a medical case was higher than it was in other allegations of negligence, substantially on the basis that the doctor's status in the community should be protected. Moreoever, he also used the - as yet untested - fear of defensive medicine to impose an additional burden on the pursuer/plaintiff.[115]

It is clear, in summary, that a duty of care arises on the doctor's offer to treat. However, the boundaries of that duty may be less than clear. It is necessary therefore to consider what are, or might be, the constituent elements of the doctor's duty to his or her patient. In so doing, a number of potential, and apparently common sense, duties will be considered, in conjunction with decisions taken by courts. It is not suggested that the examples used need be taken as definitive of what might optimally be expected of medicine. Merely, they offer some examples of situations in which patients might reasonably feel that they have rights in the medical enterprise.

## The Duty to Treat

When the doctor accepts a patient, then he or she undertakes duties of care in that respect, some of which derive initially from acceptance of the professional duties outlined in the Hippocratic Oath.[116] The fundamental duty towards the patient, as defined in the Oath, is to do his or her best for that individual patient. Of course, the definition of what is best may vary with the circumstances of each situation. Thus, whilst a doctor, surrounded by the best of medical facilities in a hospital, may be expected to perform complicated surgery as part of the general duty of care towards the patient, the actual degree and type of medical treatment which is deemed to be acceptable may alter with the situation. What is demanded of the doctor may then change, not only in the emergency situation discussed above, but also when his or her intervention is merely for the examination of a person for employment or insurance purposes. The doctor's duty very broadly in this sense is to treat to the same standard of care as he or she initially claimed to have possessed.[117]

## The Duty to Attend

A private patient can, of course, summon the doctor to attend at any time, and the doctor may successfully be sued in negligence or in contract (or both) for failure to answer this summons.[118] The National Health Service patient also has the right to summon the doctor on whose list he or she is, and the nature of the doctor's contract requires him to provide all proper and necessary treatment.[119] Of course, decisions about the nature of a failure in the duty to attend, if there is one, may also be dependent on assessing whether or not the person who summoned the doctor provided adequate and pertinent information in order that the doctor could assess the need for attendance. Of necessity, the doctor on duty will establish priorities, but it is not beyond the bounds of possibility that a doctor could be negligent in not attending quickly enough at a case even where, on information received, there was no apparent cause to assume that the patient was in grave danger. However, this is unlikely - the normal expectation being that when the doctor is summoned he or she will attend as quickly thereafter as possible. However, in some situations the requirement that the doctor attends, and follows up any given therapy, may be much more clear.

This was clearly demonstrated in the case of Corder v. Banks[120] in 1960. In this case a plastic surgeon operated to remove excess fat from below the patient's eyes. The operation was carried out on an out-patient basis, and the patient was told that, were bleeding to occur within forty-eight hours, prompt treatment would be necessary to prevent permanent disfigurement. In the event, bleeding did occur and the patient's call to the doctor went unheeded. The court held that there was a duty on the surgeon to provide post-operative care, and that since the doctor had made it clear that he would be available to be summoned by telephone, then it was also his responsibility - which he had failed to fulfill - to ensure that the telephone was properly manned. His failure in that respect was held to be negligent, and damages were awarded in respect of the patient's disfigurement.

## The Duty to Treat in Accordance with Established Medical Practice

The question of experiments in medicine will be considered in more detail later,[121] but departure from accepted practice merits some consideration at this point as a possible aspect of the doctor's general duty towards his patient in the routine medical enterprise. However unreasonably, where there is an accepted school of thought in respect of treatment, the patient might expect that the doctor will carry out this particular therapy. However, there are inevitable variations in medical practice which can render it extremely difficult to establish that a particular school of thought was in fact predominant. Indeed even where this is shown, it may be extremely difficult to establish that another school of thought (that selected by the instant doctor) is either wrong or inappropriate. It is obvious that doctors, confronted with the same condition, may opt for different therapies. Thus, the law has concentrated on the reasonableness of the choice of therapy rather than on its nature. Nowhere is this more clearly evidenced than in the court's statement in the case of Hunter v. Hanley[122] - a case which provides the authority for most commonwealth jurisdictions in this matter.

This case involved an action of damages against a doctor, resulting from a situation in which the patient was given an injection during the course of which the needle broke. It was alleged that the doctor had used a different gauge of needle from that which would normally be used and had therefore failed to exercise due skill and care. In a much cited dictum it was said that:

> To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all, it must be proved that there is a usual and normal practice; secondly, it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.[123]

As Lord Clyde further said:

> In the realm of diagnosis and treatment, there is ample scope for genuine difference of opinion and one man is clearly not negligent because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for

> establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.[124]

At first sight, this case seems to suggest that, where a doctor has abided by a usual or normal practice, he or she will not be guilty of negligence in the absence of other evidence of it. Yet it has been held in other disciplines that, even although a practice is widely used, it may yet be negligent if it is shown to be sufficiently risky or unprofessional,[125] and presumably the same would apply in medical cases. Indeed, the test in Hunter v. Hanley was followed, although partially restated, in the case of Clark v. Maclellan & Another.[126] In this case, Peter Pain, J. described the difference between situations where there is a choice of therapy and those where there is not. As he said:

> ...where there are two schools of thought as to the right course to be followed, he [the doctor] may not be charged with negligence simply because he chooses one course rather than the other. Where however there is but one orthodox course of treatment and he chooses to depart from that, his position is different. It is not enough for him to say as to his decision simply that it was based on his clinical judgement. One has to inquire whether he took all proper factors into account which he knew or should have known, and whether his departure from the orthodox course can be justified on the basis of these factors.[127]

The judgement in Hunter v. Hanley shows the significance attached by courts to the concept of ordinary medical practice, or demonstration of <u>reasonable</u> levels of skill and care. The crucial question, therefore, relates to the standard of practice which courts feel to be reasonable. Clearly, a high standard of care might be expected of the medical profession, not only because of the inherent risks of medical practice, but also because of the professional expertise which doctors claim to have and which forms the basis of consultation decision. The standard will of course vary according to the status of the doctor. Thus the consultant practising in a particular area of medicine, may be expected to demonstrate a very high standard of care.[128] The specialist who holds him or herself out as possessing special qualifications and skills will equally be expected to demonstrate those skills at that high level.

The concept of failing in professional skill, so central to the decision in <u>Hunter</u> v. <u>Hanley</u>, is not therefore an absolute one. Practice may vary from area to area, and the doctor's professional qualifications may help to define the standard of skill and care which he or she can be expected to demonstrate. The doctor who holds him or herself out to be a specialist will be expected to provide a different standard of care from that to be expected of more junior colleagues, or of a general practititioner. In passing, it is worth noting that the application of this rule has resulted, in some parts of the United States, in a move away from specialisation - a move away from higher expectations. Indeed, in that same country, in recent times there seems even to be a move within those left in specialisations, away from certain of them which are regarded as particularly high risk.[129] Interestingly, the recommendation of the (Merrison) Committee on the Regulation of the Medical Profession[130] that specialist training should be given to all general practitioners has not been implemented, but could have had implications for the standards to which they were expected to aspire in the United Kingdom..

The standard generally set by law is, then, that of the ordinary practitioner acting with ordinary competence. The doctor is therefore not required to demonstrate outstanding skill, and the modern statement of this is contained in the 1959 case of Patch v. Board of Governers, United Bristol Hospitals.[131] In this case, it was said:

> The liability of doctors is not unlimited: the standard of care required of them is not that standard shown by exceptional practitioners. Surgeons, doctors and nurses are not insurers. They are not guarantors of absolute safety. They are not liable in law merely because a thing goes wrong ....... The law requires them to exercise professionally that skill and knowledge that belongs to the ordinary practitioner.[132]

Importance, therefore, is placed on the assessment of what is the 'ordinary' practitioner - evidence which is likely to be provided by doctors themselves. Thus, doctors' expectations of the professional expertise of themselves and their colleagues will affect the standard which is expected by the law. Whilst this cannot serve to lower the standard below that of the reasonable practitioner, it could serve to raise the standard if the medical profession so wished. Moreover, it is clear that in assessing the doctor's behaviour, not only the degree of specialisation which he or she holds him or herself out as having will be important, but equally the relative experience of the doctor may play a significant part in assessing whether or not he or she was negligent.[133] However, it is also clear that the law expects, and good medical practice also expects, both the exercise of due care and skill and a recognition by the individual of his or her own limitations. As was said in the case of R v. Bateman[134], '[i]t is no doubt conceivable that a qualified man may be held liable for recklessly undertaking a case which he knew or should have known to be beyond his powers.'[135]

## The Duty to Make an Accurate Diagnosis

No doctor directly or indirectly implies that he or she will make an accurate diagnosis, and so an inaccurate diagnosis would not necessarily found a successful action for negligence unless the reasonable practitioner, acting with ordinary skill and care, could be expected to have diagnosed correctly, or there was some basic fault in the technique adopted. Whatever patients may expect of medicine, and this may well include an accurate diagnosis of their condition, the law does not require this. This is amply demonstrated by the case of Whiteford v. Hunter and Gleed.[136]

In 1942 Mr Whiteford consulted Dr Gleed in relation to retention of urine. In the belief that surgical treatment might be required, the doctor quite properly referred his patient to a specialist. As the result of the examination the specialist concluded that Mr Whiteford was suffering from an inoperable carcinoma although no biopsy was performed, nor was the normal cystoscopic examination made prior to opening the bladder. After the operation, the family were informed of the diagnosis of cancer and told that the life expectancy of the patient was a matter of months. Mr Whiteford gave up his job, sold his house and he and his wife moved to America where his wife's family lived. After some time had elapsed, Mr Whiteford was encouraged to consult another doctor in the United States who, on operation, was able to identify the problem, but found no trace of cancer. After the operation Mr Whiteford and his wife returned home, and an action for damages was raised against Dr Gleed and the specialist. At the hearing it was held that Dr Gleed could not be expected to possess the necessary skill to refute the diagnosis of the specialist and therefore he could not be held responsible. Indeed, Dr Gleed had acted with due professional skill and care in referring his patient to the specialist.

On the first hearing of the case, the specialist was held to have been negligent in failing to make an accurate diagnosis, but on appeal he was held not to have been negligent because he could not be expected to diagnose everything correctly and - significantly - the evidence of eminent specialists was that he had not deviated from acceptable practice even in not carrying out cystoscopic examination or a biopsy. However, in the case of Elder v. Greenwich and Deptford Hospital Management Committee,[137] a Casualty Officer was held negligent in failing to diagnosis appendicitis in an eleven year old child who complained of acute abdominal pain and vomiting. She was sent home and instructed to return if the pain continued, but later died at home. The position, therefore, seems to be that the doctor, whilst not guaranteeing to diagnose an illness correctly, may be found negligent in some situations where the obvious diagnosis should have been made.[138]

## The Duty to be Well-Informed

Again, to some extent, whether or not this duty exists may depend on the status of the individual doctor and the reasonableness of expecting him or her to keep abreast of developments. There is, of course, no obligation on any doctor to subscribe to any particular school of medical thought nor to subscribe to any particular form of treatment or diagnosis. Being well-informed might, however, arguably be a sine qua non of practising as a reasonable practitioner, since this last assumes a degree of knowledge. Indeed, failure to keep abreast of current literature in the doctor's own field may result in situations where the doctor is unaware that a practice that he or she has used satisfactorily over a long period of time has effectively been discredited. Thus, whilst on the one hand there may be credibility attached to using standard practice, on the other to do so unquestioningly can result in risk to the patient and perhaps also to the doctor.[139]

This very issue arose in the case of Crawford v. Board of Governors, Charing Cross Hospital.[140] The incident arose out of an accident in the course of a blood transfusion, and the action rested on the allegation that the doctor had been negligent in failing to keep abreast of modern techniques. The patient underwent an operation on his bladder, during which he received a blood transfusion. He had lost the use of one arm previously as the result of polio, and when he recovered from the anaesthetic it was discovered that he had lost the use of his other arm also. It was clear that this had resulted from treatment of the arm during transfusion. The case was heard in 1953, and an article published in 1950 was shown to have discredited the particular form of treatment used during this transfusion, outlining the possible dangers, including the one which occurred in this case. The doctor had not read this article, and was therefore unaware of the dangers in what had been a fairly common practice. The Court of Appeal finally held that mere failure to keep abreast of the medical press was not sufficient evidence of negligence, although the original judge had felt that there was a duty to follow up writings which were of particular relevance to the given doctor. In fact, it was admitted by the doctor that he knew of the existence of the article, but had failed to read it. As an aside to this case, it is interesting to ponder on what would have been the conclusion had the doctor read the article, but exercised his clinical judgement in not following the new procedure.

Although it would seem, then, that the doctor is not legally bound to keep up to date, there are some situations where he or she has a ready source of information available, to which attention should be directed, and which might result in the raising of an action in negligence, even if unsuccessful, which suggests that every effort should be made to maintain knowledge at current levels. For example, it is a statutory requirement on pharmaceutical companies that they prepare and send to doctors a data sheet on all their products.[141] The information contained in the data sheet includes comments on special precautions, contra-indications and highlights those situations where it is felt that particular patients might be at special risk. It is not inconceivable that a doctor who fails to note the contra-indications may find him or herself guilty of negligence when known dangers subsequently occur.

The position of the doctor who fails to keep abreast was further stated in Barnett v. Chelsea and Kensington Hospital Management Committee[142] which followed the statement in Hunter v. Hanley[143] that a doctor cannot simply use the same techniques where they have been shown not to equate to what is regarded by the majority of medical opinion as good and proper practice.[144]

## Duty to Communicate with Other Doctors

This particular duty would apply to general practitioners notifying specialists, specialists notifying general practitioners, casualty officers communicating with the doctor of the patient admitted as an emergency case, and so on. Although the duty to communicate with others doctors may not be a legal one it is nonetheless one which is of prime importance, particularly as the result of the decision in Chapman v. Rix.[145]

Mr. Chapman was a butcher who injured himself with a knife when boning some meat. Doctor Rix who was on the staff of the local hospital was summoned. He advised that the patient be transferred to hospital so that a more extensive examination could be carried out. Doctor Rix, himself a general practitioner, then re-examined the patient at the hospital, as there were no resident surgical staff. In his opinion, the wound extended to the deeper layers of the abdominal wall but there had been no penetration of the peritoneum. The wound was stitched, and the patient was sent home with explicit instructions to contact his own doctor and inform him of what had occurred. Doctor Rix, however, did not communicate with the patient's own doctor in any way. The patient summoned his own doctor that evening, by which time he was suffering from abdominal pain and nausea, and told his doctor that he had received treatment for an abdominal wound which had been said to be superficial. His doctor enquired no further, and was under the impression that Mr Chapman had been seen by a Casualty Officer, not realising that the hospital in which he was examined was a Cottage Hospital without surgical staff and that the examination had been, in fact, by another general practitioner. He therefore dismissed the abdominal injury as a factor in his patient's condition and diagnosed a digestive upset. Peritonitis set in and the patient died five days later. Post-mortem examination showed that there had been penetration of the peritoneum, and that the small intestine had been perforated by the knife at the time of the accident. The widow sued Doctor Rix on several grounds, but he was found at first instance to have been negligent only on the basis of his failure to communicate with Mr Chapman's own doctor. Doctor Rix appealed successfully, and Mr. Chapman's widow appealed to the House of Lords, where the decision of the Court of Appeal was upheld by 3:2. Lords Keith and Denning dissented, feeling that the patient's own doctor should have been told by Dr. Rix of the circumstances.

## The Duty to Treat Adequately

One important recent case in this area is the case of Whitehouse v. Jordan.[146] In this case, it was alleged that during a difficult labour and birth, the doctor had pulled too hard and too long on the forceps, resulting in the child being born brain damaged. In the Court of Appeal, Lord Denning indicated that whilst there may have been an error of judgement on the doctor's part, an error of judgement could never amount to negligence.[147] The allegation that the doctor had failed to treat his patient adequately was dismissed by the court. The House of Lords upheld the ultimate decision of the Court of Appeal, but in so doing overturned Lord Denning's view that an error of judgement would never be negligent.[148]

The question of what amounts to adequate treatment is, of course, one which offers major scope for interpretation. If 'adequate' means always being successful, or never causing damage, then this would clearly be an unreasonable burden to place on the doctor.[149] Equally, however, if it does not at least imply an expectation of these then it cannot be of sufficient stringency to meet the needs, and the expectations, of the patient. 'Adequate' has tended, therefore, to be interpreted as being a balance between the interests of the patient in not being harmed (although the alleged rise in iatrogenic disease must be considered here,[150]) and the right of the doctor to claim clinical judgement and freedom in the operation of his or her skills. Since there is no standard medical situation, and given that the technique chosen cannot therefore be standardised, the doctor must have reasonable scope in which to make choices about the type of therapy which is appropriate and the way in which he or she will carry it out. Always, of course, this is subject to the rule in Hunter v. Hanley[151] as to reasonableness.

## Summary

It can be seen, therefore, that the doctor is, on a practical basis, in a vulnerable position in relation to the risks inherent in his or her profession. Even a minimal degree of error, carelessness or recklessness short of actual negligence, may result in serious, and sometimes fatal, damage to the patient concerned. It is, therefore, deemed to be essential - if the benefits of medical practice are to be protected - that a balance is struck in terms of liability. However, it is also clear from the foregoing examples of potential duties, that it is particularly difficult to pin down, beyond the very vaguest terms, what duties a doctor does in fact have, or rather the level at which failure in these duties will be held to be legally culpable.

In some situations it might seem that the doctrine of <u>res ipsa loquitur</u> would apply - for example, in cases where there has been a failure to remove swabs from a patient undergoing surgery, or where the wrong leg has been amputated. Whilst the latter situation is clearly culpable, the former seems less inevitably so, and, as was already mentioned, in the case of <u>Mahon</u> v. <u>Osborne</u>,[152] it was held that failing to remove swabs did not amount to negligence.

Moroever, the difficulties of assessing the level at which complex professional duties should be measured cannot be underestimated. This is a problem which, of course, applies equally to specialisms and professions other than medicine. Finally, there is the question of the general standards which are imposed on doctors by organisations extraneous to medicine, such as society and the judiciary. As a legal concept, it has been claimed that there are basic rules of negligence which courts will apply without favour, demanding higher standards from those taking bigger risks, and (although there may be problems in the communication and understanding of technical information) applying the same fundamental rules to all groups. The question remains whether or not this is true in allegations of medical negligence.

It may seem, and indeed it has been claimed by some, that the doctor is, on the contrary, placed in a special category by the law.[153] There is a certain amount of evidence, certainly, which would suggest that considerations other than the purely technical or legal, do seem to carry weight, at least in some decisions about the quality of medical care. Primarily, as has been seen, the belief in medicine (and by implication its practitioners) as being a social good may lead to a certain reluctance on the part of the public, the legislators and the courts to criticise or challenge the doctor who is a representative of a caring and vital profession. However, even if it can be accepted that it is necessary to take the rough with the smooth in order to benefit the general welfare, judges (and particularly Lord Denning,[154]) have sometimes articulated other, and perhaps less acceptable, reasons for placing the doctor in a special category. Judicial reluctance to find a doctor negligent is, however, not immutable. In specific respect of the suggestion that the burden of proof is higher in such cases, it was recently said in <u>Ashcroft</u> v. <u>Mersey Regional Health Authority</u>[155] that:

> The question for consideration is whether on

> a balance of probabilities it has been established that a professional man has failed to exercise the care required of a man possessing and professing special skill. <u>If there is an added burden, such burden does not rest on the person alleging negligence; on the contrary, it could be said that the more skilled a person is the more the care that is expected of him</u>.[156](emphasis added)

It was mentioned in passing earlier in this discussion that both doctors and patients in the United States are said to be suffering as a result of the growth of defensive medicine. It is a commonly expressed fear in the British courts that if doctors are found to be negligent too often, and perhaps even if there is facilitation of the raising of actions against doctors, this will inevitably lead to the practice in the United Kingdom of this same defensive medicine. This extra-legal consideration not only goes beyond the definition of negligence <u>per se</u>, it also but rests on several challengeable assumptions which are worth a brief mention. It does not necessarily follow that facilitation of genuine complaints would result in litigation spiralling out of control. Whilst the experience in the United States might suggest that this could indeed be the result, blandly to accept its immediate translation into the United Kingdom, is to ignore considerable differences between the structures of the societies and their legal systems.

Doctors in the United States occupy a different, and often considerably wealthier, social position from that of their counterparts in the United Kingdom. It may be, for example, that patients in the United States are less reluctant to sue a doctor, given that they perceive him or her as wealthy rather than caring. Equally, the contingency-fee system operated by lawyers in the United States means that the patient takes no real risk in suing what, in the long run, will in most cases be an insurance company rather than the individual doctor or a service to which everyone subscribes, such as the National Health Service. Whilst lawyers may claim that the contingency fee system permits them to take cases which would otherwise be impossible to raise, and equally that they will not raise speculative cases since their work would remain unpaid, there seems little logical doubt that it does have an impact on litigation-conscious America, particularly where awards are made by juries.[157]

Moreover, it is a challengeable assumption that defensive medicine is a necessary outcome of increased litigation. In evidence to the Pearson Commission, it was the medical profession itself which argued for retention of the negligence based action as a desirable means of sustaining professional accountability.[158] Successful allegations of negligence against doctors must surely also represent that professional accountability. Equally, although perhaps more contentiously, it has been said that defensive medicine may in fact equate to optimal medicine, rather than necessarily to bad medicine.[159] This is not a suggestion on which the present writer is competent to comment, beyond the mere fact that the expense involved in defensive medicine, often criticised by commentators, cannot <u>per se</u> serve to condemn the practice.

The statements of Lord Denning in <u>Hucks</u> v. <u>Cole</u>[160] have already been mentioned, and seem to suggest that the aggrieved patient must demonstrate a degree of negligence greater than if he or she were suing another individual or professional. Kilner Brown's remarks,[161] however, may suggest that there is a judicial move away from accepting this. The implications of categorising any professional group as a special case, as Lord Denning seems to do in this example, may ultimately however be more dangerous than helpful to those concerned. Indeed, this very point was made by the Pearson Commission.[162] Commenting on the considerable shortfall in success rates between most personal injury claims and those raised against doctors, the Pearson Commission also noted that there was an increase in claims against doctors, pointing out that 50 or 60 years ago claims against doctors were relatively rare.[163] They received an estimate that in recent years the claims against doctors and dentists were running at about 500 per year, and more recently the medical profession, has claimed that allegations have again substantially increased.[164] The Commission were themselves unimpressed by suggestions that defensive medicine would necessarily result from the raising of successful actions against doctors. Moreover they pointed out that although there has been an increase in claims, the total number is still a tiny proportion of the number actually receiving medical treatment.[165]

In noting the difficulties of raising successful actions on the basis of medical negligence, the Pearson Commission felt that there were a number of possible contributory factors over and above those already highlighted. These difficulties they identified as the difficulty of obtaining access to information; the problem of obtaining the help of an expert to assess what has happened; the reluctance of fellow professionals to criticise, and the fact that medical records might be so vague as to leave considerable scope for interpretation of the doctor's behaviour.[166] The Commission felt that shifting the burden of proof in negligence cases would obviate some of the problems which they outlined, for example, in respect of access to records and so on, but on the whole they felt that it would also increase claims and defensive medicine would become more of a possibility. Therefore, they did not recommend changes to the law.[167]

In any event, the Commission was of the opinion that medical accidents were more common than actual cases of negligence.[168] For a new scheme to be satisfactory it would have to take account of this. They therefore looked at the possibility of imposing a system of strict liability but felt that this would, whilst removing the need to prove negligence, still have three major problems. First, it would necessarily preclude compensation for the foreseeable result of medical treatment; second, causation would still be very difficult to establish; and third, it might place an unreasonably rigid set of standards on the medical profession and again lead to an increase in defensive medicine.[169] As has been noted, in its evidence to the Commission the medical profession by and large favoured a retention of the fault-based action, since it claimed that acceptance of liability was one of the means whereby doctors can show their sense of responsibility and therefore claim professional freedom. To remove delict or tort from the equation would require a beaurocratisation of medicine which, it was said, would unreasonably delimit professional practice.[170]

The Commission were largely unimpressed by such claims and noted that the system at present tended to expose those doctors whose behaviour was least likely to be reprehensible. However, in order to make special and different rules for doctors, it was felt that there would have to be a very good case made for differentiating them from other professionals, and that meanwhile this could not be done.[171] Interestingly, the British Medical Association itself has recently taken a position which seems to reverse the views presented to the Pearson Commission, and which now seems to favour a system of liability without fault, such as that which exists in New Zealand.[172]

In the long run, the Commission's rejection of the strict liability scheme rested on the fact that it would still fail to compensate the majority of people, who were injured as a result of medical accident rather than medical negligence. Advances in medicine mean that the opportunity for accident expands, which might have rendered a no fault scheme more satisfactory. The effect of no-fault compensation in medical cases will be considered in a subsequent chapter.[173] Ultimately, the decision not to recommend a no-fault scheme in this area was seen as a very difficult one and hinged as much on cost as it did on principle. The Commission, however, did recommend that, in view of the problems identified with the negligence action, the option of introducing a no-fault scheme should be retained and reconsidered in the light of experiences in Sweden and New Zealand.[174]

## Conclusions

In summary, therefore, it can be seen that the entire test of negligence hinges on the question of whether or not the duties owed by a doctor to his or her patient can be identified. Without a clear definition of doctors' duties, it is impossible to assess whether or not they have been breached. Although there is a three-fold test for negligence, it has been suggested that each part of the test in fact is merely an aspect of the other.[175] In other words, the duty of care concept and its definition are inextricably linked to all aspects of the definition of negligence. Logically, unless they can be established, there is no need to consider the final element of the negligence based claim - that is, that the breach caused the harm complained of. As has been noted, the judiciary can, and often do, make policy decisions about the nature and extent of any duty owed. Where this is done in an apparently disinterested manner it traditionally neither receives nor merits condemnation.

However, it is also important to remember that judicial attitudes to the individual or group under attack may have a significant impact on the rights of the individual, and on the chances of successful litigation. A cursory examination of duties which doctors <u>might</u> owe to their patients tends to suggest that such common sense duties as the ordinary citizen might expect, do not necessarily receive legal reinforcement. This is not, it is submitted, because it would either be too onerous or unreasonable to impose such duties - at least not in all cases. Certainly to impose a duty to make an accurate diagnosis, or always to select successful treatment, or to subscribe to a certain school of thought would be an inappropriate burden to place on the medical profession. However, without going to such extremes, it might be possible to identify a standard which encompasses some of these characteristics and which protects the patient in the medical enterprise. From the foregoing it might appear at first sight that doctors in fact have very few clear-cut duties in respect of their patients.

The extensive use of extra-legal criteria in determining the doctor's responsibilities to the patient subverts both the strict application of legal rules and the source from which the doctor's duties arise. Seen from the perspective of patients' rights, it is more difficult to justify reduction of the level of care which can be expected. Moreover, as has been pointed out above, the extensive - perhaps even definitive in some cases - use of professional evidence in determining the ultimate issue before the court, will further enhance the medical profession's power in decision-making and further detract from the patient's capacity successfully to claim for harm caused.

Indeed, it might even be suggested that it is this very perceived protectionist attitude in medicine which makes the risk of patient litigation greater and which - if litigation does contribute to the growth of defensive medicine - might ultimately result in the occurrence of the very situation which courts claim to strive to avoid. Equally, it is questionable whether or not one professional group should be put in a different position from others. It was precisely to avoid this situation that the Pearson Commission, clearly concerned with lack of success in allegations of medical negligence, nonetheless refused to institute a special procedure specifically for medicine. If it is unfair or unreasonable to impose a special set of standards on the one hand, then it is difficult to see how the current legal practice of so doing in medical cases can simultaneously be justifiable.

Clearly, not only judicial interpretation, but also the nature of the action made available to patients is significant in protecting (or otherwise) their rights. For the moment, however, it is appropriate to test the negligence action specifically against the claims and concerns of those who argue that patients have a right to make choices in the medical enterprise. It has been suggested that the move from the assault to the negligence based action has radically altered both the philosophy and the practice of medical litigation, and at this stage the implications of the use of negligence as a means of resolving disputes about consent must be considered in more detail.

## NOTES

1. A more thorough and detailed analysis can be found in Walker, D.M., The Law of Delict in Scotland (2nd. Ed., revised), Edinburgh, W. Green & Son Ltd., 1981; Wilson, W.A., 'The analysis of Negligence', in Wilson, W.A., Introductory Essays on Scots Law, Edinburgh, W. Green & Son Ltd.,

1978; Rogers, W.V.H., <u>Winfield and Jolowicz on Tort</u>, (12th Ed.), London, Sweet & Maxwell, 1984; <u>Street on Torts</u>, (7th. Ed.), London, Butterworths, 1983.

2. Weir, T., <u>A Casebook on Tort</u>, (5th Ed.), London, Sweet & Maxwell, 1983.

3. <u>ibid.</u>, at p. 267.

4. c.f. Walker, <u>op.cit.</u>, at pp.8-9: 'The social function of the law of delict is to give legal recognition and protection to certain valuable interests of the individual and of groups of individuals and corporate persons. Interests are those claims or demands or desires which human beings seek to satisfy, which the legal ordering of human relationships must take account of, and which are deemed by the law to be valuable, deserving of protection, and justifying retribution or compensation if interfered with.'; <u>Winfield and Jolowicz on Tort</u>, <u>op.cit.</u>, at p. 3: 'It is the business...of the law of tort to determine when the law will and when it will not grant redress for damage suffered or threatened...'

5. For discussion of the merits of the use of the concept of fault, see <u>Winfield and Jolowicz on Tort</u>, <u>supra cit.</u>, at pp 26-31; for criticism of the fault principle see Atiyah, P.S., <u>Accidents Compensation and the Law</u>, (3rd Ed.), London, Weidenfeld & Nicolson, 1980 (reprinted 1984).

6. op.cit., at pp 8-9.

7. c.f. Livingstone v. Rawyards Coal Co. (1880) 5 App. Cas. 25 where the classic statement of the object of damages is made by Lord Blackburn, at p. 39 '...where any injury is to be compensated by damages, in setting the sum of money to be given for reparation of damages you should as nearly as possible get at that sum of money which will put the party who has been injured, or who has suffered, in the same position as he would have been in if he had not sustained the wrong for which he is now getting his compensation or reparation.'; for Scots Law, see Walker, op.cit., at p. 461. In some situations, damages may also be punitive or exemplary - c.f. Rookes v. Barnard [1964] A.C. 1129; Cassell & Co. v. Broome [1972] A.C. 1027. For a discussion of punitive or exemplary damages in English Law see Winfield and Jolowicz on Tort, supra cit., at pp.616 et seq., Street on Torts, supra.cit., at pp. 435-6. In Scots Law, Walker, op.cit., suggests (at pp. 461-2); 'There is no adequate warrant in Scotland for punitive, vindictive or exemplary damages, though in cases of deliberate wrongs damages may sometimes be aggravated by the outrageous nature of the conduct complained of and in all cases damages are aggravated by the greater gravity of the loss suffered. It is no ground for exemplary

or aggravated damages that the loss was caused by gross negligence.'

8. Cmnd. 7054/1978

9. ibid, para 262

10. c.f. Rushton v. National Coalboard [1953] 1 Q.B. 495, per Romer, L.J. at p. 502, noting that compensation, where loss is not solely pecuniary, is 'notional or theoretical compensation to take the place of that which is not possible, namely, actual compensation.' As Walker, op.cit. notes (at p. 460) 'An award of pecuniary damages is the normal form of remedy for delictual wrong, if only because pecuniary compensation, however imperfect a reparation, is the only practicable reparation for harm done unjustifiably.'

11. Winfield and Jolowicz, supra cit; Walker, op.cit.; Street on Torts, supra cit. See also Kilner Brown, J., in Ashcroft v. Mersey Regional Health Authority [1983] 2 All E.R. 245, at p. 246: 'Where an injury is caused which should never have been caused, common sense and natural justice indicate that some degree of compensation ought to be paid by someone.' See also Grant v. Australian Knitting Mills [1936] A.C. 85; Donoghue v. Concrete Products (Kirkaldy) Ltd. 1976 S.L.T. 58. For further discussion, see Forte, A.D.M., 'Medical Products Liability', in McLean, S.A.M. (ed), Legal Issues in Medicine, Aldershot,

Gower, 1981.

12. See, for example, Harris, P., *An Introduction to Law*, (2nd Ed.), London, Weidenfeld and Nicolson, 1984, at p. 49.

13. see, pp 241-44 infra

14. *Roe* v. *Wade* 93 S. Ct. 705 (1973); however, it should be noted that there is no constitutional right to privacy, rather the language of privacy is used to describe the rights to liberty, autonomy, etc. For further discussion, see McLean, S.A.M., 'The Right to Reproduce' in Campbell, *et al.* (eds), *Human Rights: From Rhetoric to Reality*, Oxford, Basil Blackwell, 1986.

15. c.f. *Katz* v. *United States* 389 U.S. 347 (1967)

16. Weir, *op.cit.*, at p. 5

17. *op.cit.*, at p. 9.

18. see Walker, *op.cit.*; *Winfield and Jolowicz on Tort*, *supra cit.*; *Street on Torts*, *supra cit.*

19. for discussion of some of the problems of this limitation, see, for example, *Winfield and Jolowicz on Tort*, *supra cit.*, esp. p. 625 *et seq.*

20. *Donoghue* v. *Stevenson* 1932 S.C. (H.L.) 31.

21. For the distinction between contract and tort/delict, and the situations where they may overlap, see Walker, *op.cit.*, *Winfield and Jolowicz on Tort*, *supra cit.*, *Street on Torts*, *supra cit.* In medical cases, see particularly *Edgar* v. *Lamont* 1914 S.C. 277; *Thake* v. *Maurice*

[1984] 2 All E.R. 513, [1986] 1 ALl E.R. 497 (C.A.)

22. For discussion of these problems, see Teff, H. and Munro, C., Thalidomide: The Legal Aftermath, London, Saxon House, 1976. As an example of the problems which confronted these children, see S. v. Distillers Co. (Biochemicals) Ltd. [1969] 1 All E.R. 1412; Distillers Co. (Biochemicals) Ltd. v. Thompson [1971] 1 All E.R. 694

23. for discussion, see Teff and Munro, op.cit.

24. for the classic statement of liability, see Donoghue v. Stevenson, supra cit.

25. Duval v. Seguin (1972) D.L.R. (3d) 418

26. Watt v. Rama [1972] V.R. 353

27. That is, the equitable principle that a child, once born alive, should be regarded as having been alive at the time the harm was caused where it is in the interests of the child so to do. See Scottish Law Commission, Liability for Antenatal Injury, Cmnd. 537/1973, at para 10, where they said 'In Scotland...the right to reparation is general in its nature, based on the existence of a fault for which the defender is responsible and which has caused foreseeable harm to the pursuer.'

28. Law Commission, Report on Injuries to Unborn Children, Cmnd. 5709/1974, which led to the passing of the Congenital Disabilities (Civil Liability) Act 1976.

29. c.f. Donoghue v. Stevenson, supra cit.

30. *supra cit.*, para 70.

31. A 'state of the art' defence essentially means that a producer cannot be held liable for damage which they could not have foreseen, at the time of manufacture, as being a possible outcome. This view is similar to that adopted in respect of medical practice by Lord Denning in *Roe* v. *Ministry of Health; Woolley* v. *Same* [1954] 2 Q.B. 66. This defence is also incorporated into the Consumer Protection Act 1987 (U.K.)

32. This requires both legal personality and the capacity to identify the wrongdoer – c.f. Lord Thankerton in *Donoghue* v. *Stevenson*, *supra cit.*, at p.59.'A man cannot be charged with negligence if he has no obligation to exercise diligence.'

33. *Donoghue* v. *Stevenson*, *supra cit.*, per Lord Macmillan, at p. 70; see also Lord Atkin, at p. 57: 'It will be an advantage to make it clear that the law in this matter as in most others is in accordance with sound common sense.'

34. (1860) 5 H. & N. 890

35. for discussion, see Walker, *op.cit.*, *Winfield and Jolowicz on Tort*, *supra cit.*, *Street on Torts*, *supra cit.*

36. The 'neighbour principle' as explicated in *Donoghue* v. *Stevenson*, *supra cit.* The test for remoteness of damage is similar – see *Overseas Tankship (U.K.) Ltd.* v. *Morts Dock and Engineering*

Co Ltd. (The Wagon Mound) [1961] A.C. 388, which declared the earlier case of Re Polemis and Furness, Withy & Co Ltd. [1921] 3 K.B. 560 to be wrongly decided. As Winfield and Jolowicz, supra cit., note, at p. 129, in Re Polemis '...there are passages which seem to suggest that once an act has been found to be negligent in the sense that injury to someone is foreseeable, then any person directly injured by it can recover even though it is unforeseeable that he might suffer damage in any way. This, however, would clearly conflict with the basic principle that before liability in negligence can exist there must be a breach of duty owed to the plaintiff.' See also Lord Wright, 'Re Polemis' (1951) 14 M.L.R. 393; Bourhill v. Young 1942 S.C. (H.L.) 78; Goodhart, 'Liability and Compensation' (1960) 76 L.Q.R. 567; Hughes v. Lord Advocate 1963 S.C. (H.L.) 31.

37. supra cit.

38. per Lord Macmillan, at p.70: 'The cardinal principle of liability is that the party complained of should owe to the party complaining a duty to take care, and that the party complaining should be able to prove that he has suffered damage in consequence of a breach of that duty.'

39. Junior Books Ltd. v. Veitchi Co. Ltd. [1982] 3 All E.R. 201.

40. [1963] 2 All E.R. 575

41. [1970] 2 All E.R. 294

42. [1978] A.C. 728

43. _ibid._, at pp 751-2

44. [1982] 2 All E.R. 298.

45. per Lord Bridge, at p.319

46. _id._

47. e.g. _British Railways Board_ v. _Herrington_ [1972] 1 All E.R. 749; see also _Glasgow Corporation_ v. _Taylor_ [1922] 1 A.C. 44; _Munnings_ v. _Hydro-Electric Commission_ (1971) 45 A.L.J.R. 378; _Edwards_ v. _Railway Executive_ [1952] A.C. 737; _Woolridge_ v. _Sumner_ [1962] 2 All E.R. 978; _Nettleship_ v. _Weston_ [1971] 3 All E.R. 581.

48. Weir, _op.cit._, at p. 10

49. 1943 S.C. (H.L.) 3

50. _ibid._, at p. 10

51. _supra cit._

52 at p.88.

53. per Lord Macmillan in _Muir_ v. _Glasgow Corporation_ 1943 S.C. (H.L.)3, at p.10

54. Lord Radcliffe in _Davis Contractors_ v. _Fareham_ [1956] A.C. 696, at p. 728; Atiyah, _op.cit._ at pp 38-42 identifies some of the difficulties in the concept of reasonableness.

55. c.f. _Hunter_ v. _Hanley_ 1955 S.C. 200; _Lanphier_ v. _Phipos_ (1838) 8 C & P 475. As Walker, _op.cit._, puts it (at p.205) 'Where a person has undertaken

any task for which special skill and knowledge is required, particularly the skill of a recognised trade or profession, the law requires of him to display a competent measure of the skill and knowledge usually found in persons who undertake such matters.'

56. R. v. Jordan [1977] A.C. 699, per Lord Wilberforce at p. 718 '...ordinary human nature, that of people at large, is not a subject of proof by evidence, whether supposedly expert or not.'

57. see chapter 2, supra.

58. This can be inferred from the general role of the court as the ultimate and independent decision-making tribunal.

59. Literally, the facts speak for themselves.

60. [1939] 1 All E.R. 535.

61. 1962 S.C. (H.L.) 70.

62. at p. 83.

63. supra cit.

64. at p. 574.

65. supra cit.

66. at pp. 422-423

67. c.f. Teff and Munro, op.cit.; Pearson Commission, supra cit., at para 1456.

68. Teff and Munro, op cit.

69. id.

70. As it is, compensation was awarded ex gratia only after an extensive media campaign. Even that

campaign was legally threatened in the European Court: for discussion, see Robertson, A.H., Human Rights in Europe, (2nd Ed.), Manchester, Manchester University Press, 1977; see also, S. v. Distillers Co. [1970] 1 W.L.R. 114

71. supra cit., at para 1449, where they noted 'Our consultations have led us to the conclusion that, as the boundary of knowledge increases, so does the area of certainty.'; see also, para 1450: 'We received no evidence that causation is becoming easier to establish.'

72. c.f. Lord Denning's description of the role played by the concept of duty of care in Roe v. Ministry of Health, supra cit., at p. 44 '...it can be argued that the only necessary function performed by the duty of care concept in the present law is to deal with those cases where liability is denied not because of lack of proximity but for reasons of legal policy and that in all other cases (the great majority) everything can be handled by asking whether the defendant behaved with the prudence of a reasonable man.'

73. c.f. Gamble, A.J., 'Professional Liability' in McLean, op.cit.

74. Weir, op.cit., at p. 8

75. see chapters 1 and 2, supra.

76. For discussion, see McLean, S.A.M. and Maher, G., Medicine, Morals and the Law, Aldershot, Gower,

1983 (reprinted 1985) chapter 8.

77. For discussion, see Brazier, M., Medicine, Patients and the Law, Harmondsworth, Penguin, 1987, at p. 6 'Doctors may be changing slowly, but the perception of many patients has not changed. They still regard the doctor as a miracle worker, and the publicity attaching to and money pouring into high-technology medicine reinforce that perception.'

78. For example, access to medical records may be of vital importance, and yet is limited by the Administration of Justice Act 1970 and the Administration of Justice (Scotland) Act 1972 and the Data Protection Act 1984. See also McGown v. Erskine & Ors. [1978] 2 All E.R. 625; Dunning v. United Liverpool Hospitals' Board of Governors [1973] 2 All E.R. 454; Lee v. South West Thames R.H.A. [1985] 2 All E.R. 385. For further discussion see Brazier, op.cit., at pp.45-49, and chapter 6.

79. see discussion in chapter 1, supra.

80. for discussion, see Gamble, loc.cit.; Harland, W.A. and Jandoo, R.S. 'The Medical Negligence Crisis' (1984) 24 Med.Sci.Law 123.

81. As Brazier, op.cit., notes at p. 14, 'More and more patients are resorting to litigation....insurance against professional liability costs [doctors]...more and more each

year.'

82. c.f. Brazier, op.cit., ch. 1; McLean and Maher, op.cit. Equally, of course, as Brazier op.cit. notes (at p. 7) 'The price of power is that those who exercise it can today expect constant scrutiny from those subject to it and from the public at large. The age of deference is past.'

83. Illich, I., Limits to Medicine. Medical Nemesis: The Expropriation of Health, Harmondsworth, Penguin, 1985 edition.

84. Kennedy, I., The Unmasking of Medicine, London, George Allen & Unwin, 1981.

85. Illich, op.cit., at p. 38.

86. for discussion of the Law Society's Consultation paper, see Law Magazine, 10 July 1987, 5.

87. For examples of the various possible interpretations of this term, see Wood, C., (ed), The Influence of Litigation on Medical Practice, London, Academic Press, 1977.

88. see chapter 1, supra. See also the comments of Lord Denning in Lim Poh Choo v. Camden and Islington A.H.A. [1979] 1 All E.R. 332.

89. supra cit.

90. see, the Pearson Commission, supra cit., paras 1316-1318

91. Harland, and Jandoo, loc.cit.

92. Pearson Commission, supra cit., para. 1326; see also, Jones, M.A., 'Medical Negligence - The

Burden of Proof' (1984) <u>134</u> <u>N.L.J.</u> 7.

93. 'The Times' 2 July 1954.

94. <u>id.</u>

95. <u>Edgar</u> v. <u>Lamont</u> 1914 S.C. 277.

96. For discussion of the applicable standard, see Mason and McCall Smith, <u>op.cit.</u>, at pp. 166-175; <u>Wilsher</u> v. <u>Essex Area Health Authority</u> [1986] 3 All E.R. 801; Dyer, C., 'Is Inexperience a Defence Against Negligence?' (1986) <u>293</u> <u>B.M.J.</u> 497; <u>Jones</u> v. <u>Manchester Corporation</u> [1952] 2 Q.B. 852.

97. For a brief discussion of this see Mason and McCall Smith, <u>op.cit.</u> at p. 145; see also Sullivan, B, 'Some Thoughts on the Constitutionality of Good Samaritan Statutes' (1982) <u>8</u> <u>Amer. J. Law Med.</u> 27.

98. c.f. McLean and Maher, <u>op.cit.</u>, at p. 158, 'While some discussion in the past centred on the problems of establishing the duty required by law, it is now clear that the offer to treat is sufficient to create the legal duty...'

99. <u>supra cit.</u>

100. <u>ibid.</u>, at p. 279.

101. although any growth in private medicine may change this and may raise different expectations. See, for example, <u>Thake</u> v. <u>Maurice</u> [1984] 2 All E.R. 513, but note the change in the basis of liability in [1986] 1 All E.R. 497 (C.A.)

102. [1909] 2 K.B. 820

103. [1951] 2 K.B. 343

104. Brazier, op.cit., at p. 244 'Having no contract with his G.P., an aggrieved patient seeking compensation...must sue in negligence.'; see also, Mason and McCall Smith, op.cit., at p. 163: 'If an allegation of negligence on the part of a general practitioner is made, the plaintiff may then proceed directly against the doctor in question. The general practitioner in the United Kingdom is solely responsible for the treatment of his patients and there can be no question of responsibility being imposed on a health authority unless the authority has intervened in the practitioner's treatment of his patient....'

105. Knight, B., Legal Aspects of Medical Practice, (3rd. Ed.), Edinburgh, Churchill Livingstone, 1982, at p. 58: '...a series of decided cases beginning some 40 years ago, introduced first the acceptance that hospitals were responsible or jointly responsible for the negligence of their non-medical staff, and then, especially with the advent of the National Health Service, this concept was extended to cover medical staff.'; for further discussion, see also Mason and McCall Smith, op.cit., at p. 164.

106. This is certainly an ethical duty, in the terms of the Hippocratic Oath, although the exceptions to

the duty of confidentiality are now substantial. For discussion of this, and possible legal remedies in the event of breach of confidence, see Mason and McCall Smith, op.cit., ch. 8, p. 136 et seq.

107. supra cit.

108. at p. 84.

109. at p. 86.

110. supra cit.

111. [1980] 1 All E.R. 650 (C.A.)

112. [1981] 1 All E.R. 267 (H.L.)

113. For discussion, see McLean, S.A.M., 'Negligence - A Dagger at the Doctor's Back?', in Robson, P. and Watchman, P., (eds), Justice, Lord Denning and the Constitution, Aldershot, Gower, 1981.

114. 'The Times' 9 May 1968.

115. Roe v. Ministry of Health, supra cit., at pp. 83 and 86.

116. now restated in the Declaration of Geneva.

117. e.g. in R. v. Bateman (1925) 41 T.L.R. 557; Gamble, loc.cit., describes the duty of care explicated in this case as follows (at p. 89) 'A medical practitioner was stated to be under a duty to his patient to use diligence, care, knowledge, skill and caution in his administration of treatment. The standard was stated to be a fair and reasonable one of care and competence...'; see also Barnett v. Chelsea and Kensington H.M.C.

[1969] 1 Q.B. 428; see also, Hunter v. Hanley, supra cit., per Lord Clyde at p. 205 '"Reasonable care and skill" is therefore what is reasonable for a qualified member of that trade or profession, such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care.'; Bolam v. Friern H.M.C. [1957] 2 All E.R. 118; Whitehouse v. Jordan, supra cit.

118. Corder v. Banks 'The Times' 9 April 1960

119. As Knight, op.cit., says (at p. 52): 'Although often a matter for NHS Committees and Tribunals...failure of a general practitioner to respond to a request for attendance may form grounds for an action in negligence.'

120. supra cit.

121. see infra, pp.351-364

122. supra cit.

123. ibid., at p. 206

124. ibid., at p. 217

125. Paris v. Stepney Borough Council [1951] A.C. 367; General Cleaning Contractors v. Christmas [1952] 2 All E.R. 1116; Barkway v. South Wales Transport [1950] 1 All E.R. 402; Lloyd's Bank v. E.B. Savory & Co. [1933] A.C. 233

126. [1983] 1 All E.R. 416.

127. ibid., at pp. 424-5

128. see Wilsher, supra cit.; Maynard v. West Midlands R.H.A. [1984] 1 W.L.R. 634. It should be noted

that the standard, although different, remains nonetheless that of the reasonable practitioner at that level of skill.

129. See the comments of Lord Denning in Whitehouse v. Jordan, supra cit. (C.A.) at p. 658, talking of the American experience in particular, 'There, the damages are colossal....Experienced practitioners are known to have refused to treat patients for fear of being accused of negligence. Young men are even deterred from entering the profession because of the risks involved...'; see also, Wood, op.cit. for further discussion.

130. Report of the Committee of Inquiry into the Regulation of the Medical Profession, Cmnd 6018/1975.

131. (1959) B.M.J. 701.

132. at p. 702

133. but see Wilsher, supra cit.

134. supra cit.

135. at p. 560

136. (1950) 94 Sol. Jo. 758 (H.L.)

137. 'The Times' 7 March 1953.

138. Hunter v. Hanley, supra cit.; Maynard, supra cit.; Wood v. Thurston 'The Times' 25 May 1951; Crinon v. Barnet Group H.M.C. 'The Times' 19 November 1959; Langley v. Campbell 'The Times' 6 November 1975; Tuffil v. East Surrey A.H.A. 'The Times' 15 March 1978.

139. c.f. Hunter v. Hanley, supra cit., where it was made clear that a doctor could not obstinately hang on to a discredited practice.

140. 'The Times' 8 December 1953.

141. Medicines Act 1968.

142. supra cit.

143. supra cit.

144. supra cit.

145. (1959) 2 B.M.J. 1190

146. supra cit.

147. [1980] 1 All E.R. 650, at p. 658

148. [1981] 1 All E.R. 267, at p. 281; see also Robertson, G., 'Whitehouse v. Jordan - Medical Negligence Retired' [1981] 44 M.L.R. 457

149. see Patch v. Board of Governors, United Bristol Hospitals, supra cit.

150. for discussion, see Illich, op.cit.

151. supra cit.

152. supra cit., but see Urry v. Bierer 'The Times' 15 July 1955. See also the comments of Peter Pain, J., in Clark v. MacLellan, supra cit., at p. 427, 'It seems to me...that where there is a situation in which a general duty of care arises and there is a failure to take a precaution, and that very damage occurs against which the precaution is designed to be a protection, then the burden lies on the defendant to show that he was not in breqch of duty as well as to show that the damage did not

result from his breach of duty.'

153. c.f. Gamble, loc.cit., who says at p. 89: 'There has been a surprisingly strong emphasis on policy, not so much to expand, but rather to limit, the application of negligence to doctors.'

154. for discussion, see Robertson, loc.cit.; McLean, loc.cit.

155. supra cit.

156. at p. 247

157. for further discussion, see Wood, op.cit.

158. In evidence to the Pearson Commission, supra cit., the medical profession claimed (para 1342) that: 'Liability was one of the means whereby doctors could show their sense of responsibility and, therefore justly claim professional freedom. If tortious liability were aboloshed, there could be some attempt to control doctors' clinical practice to prevent mistakes for which compensation would have to be paid by some central agency...this could lead to a bureaucratic restriction of medicine and a brake on progress.'

159. Wood, op.cit.

160. supra cit.

161. in Ashcroft v. Mersey R.H.A., supra cit.

162. para 1318.

163. para 1323.

164. para 1327.

165 although they did suggest that the possibility of

a modification of the system should be borne in mind, and that the schemes operating in Sweden and New Zealand should be monitored.

166. para 1348.

167. paras 1364-1369

168. para 1342.

169. para 1344.

170. For one view, see Smith, R., 'Problems with a no-fault system of accident compensation' (1982) <u>284</u> <u>B.M.J.</u> 1323

171. see chapter 7, <u>infra.</u>

172. para 1371.

173. per Lord Denning in <u>Roe</u> v. <u>Ministry of Health</u>, <u>supra cit.</u>, at p. 86.

# CONSENT AND NEGLIGENCE

## CHAPTER 5

It has been indicated that the assault-based action, whilst showing superficial promise as a method of emphasising patient autonomy as a fundamental value in the medical enterprise, nonetheless also carries inherent in it substantial flaws. Not merely might it seem distasteful or inappropriate that it should be used against an essentially beneficent discipline, but also doubts about whether or not 'touching' is essential to the allegation make it a less than universally useful tool. Further, of course, it would certainly be stretching the credibility of language were what in reality amounts to a failure to act by, for example, the doctor not providing any information about available therapy, to be described as an assault.[1]

Equally, the application of the negligence doctrine in routine cases of medical malpractice has been said to be somewhat less stringent than it is in other cases.[2] The use of extra-legal policy factors in decision-making, whilst not totally unusual, is nonetheless arguably more common and more systematic in medical cases, reflecting the esteem in which orthodox medicine and its practitioners (doubtless rightly) are held in the community. Indeed, as Lawson and Markesinis[3] note, '...it would appear that nowadays lawyers seem to have recourse to...policy factors whenever their aim is to limit rather than expand delictual liability.'[4] Moreover, the logic of using expert testimony where professional decisions are made is difficult to dispute, although it may present problems for the claimant in all allegations against professional groups who clearly have an interest in not criticising their colleagues. This is equally true of doctors.

However, the extensive use of professional expert evidence to test the behaviour under criticism against the grounds for negligence is only logical to the extent that the behaviour actually concerns solely professional matters. Moreover, even although persuasive, it would be unusual were the law to hand over entirely its role as the ultimate decision maker. It may be true that:

> With matters involving technical medical expertise, a court should be extremely cautious before condemning as negligent a procedure which was performed in accordance with the common professionally approved practice.[5]

Courts nonetheless retain the right (and some might say the duty) so to do. In a number of cases, mere conformity with accepted or standard practice has been held by courts to amount to negligence.[6] Equally, in cases of medical negligence the courts have made it clear that the doctor who stubbornly holds on to old practices may be considered negligent.[7]

In medical cases, however, the situation for the aggrieved patient is further compounded by the fact that the courts hold to the principle laid down in Hunter v. Hanley.[8] Thus, deviation from normal practice is not necessarily negligent.[9] Essentially, therefore, although on the one hand the courts retain the right to insist on good, rather than merely common, practice, in truth the assessment even of what is good (albeit different or unusual) practice, will again depend on the evaluation of what the reasonable, competent doctor would have thought of this particular deviation from the norm.[10] Although the defending doctor is placed in such cases in the situation of proving that the deviation was reasonable,[11] this shift in the burden of proof will only be significant if other doctors are prepared to criticise. Without belabouring the point, the comments made above [12] in respect of expert evidence should be borne in mind.

## The Essentials of Consent

If questions of consent are to be dealt with in a similar way to matters of operational malpractice, then whether or not a fellow professional would have disclosed the information will be of crucial, if not determinative, concern. In order to assess the merit of such an approach, however, it is necessary to consider in more depth precisely what constitutes consent, and - perhaps even more fundamentally - the rationale for consent rules.

To give legally valid consent, a person must be both <u>sciens</u> and <u>volens</u>.[13] Thus, he or she must have the capacity to consent - such capacity is central to the issue. The capacity of the sane, adult human being is not in doubt - special cases will be considered below.[14] For the purposes of the present discussion, however, the prototype will be the sane adult. Moreover, it must be the case that what is consented to is something which is capable of being consented to.[15] Thus, in the criminal law, it is established that it is not possible legally to consent to assault or murder.[16] As has been seen, however, the criminal law is rarely, if ever, used in questions relating to medical practice. Most forms of therapy are capable of being consented to, although doubts have been raised about some. Lord Denning, for example, held the firm view that - even if voluntary - sterilisation was beyond the range of therapy which could be consented to.[17] However, this view was not shared by his colleagues in this case and sterilisation has become a relatively routine part of medical practice. Indeed, it has been claimed that it now represents one of the most commonly used forms of contraception.[18] Its legality on a voluntary basis is therefore scarcely in doubt.

It can safely be assumed, therefore, that even the most invasive therapy can be consented to by the patient who is both sciens and volens. Even procedures such as heart transplantation which place the patient at considerable risk are clearly not illegal in se. Indeed, it is substantially the case that debates about the legal standing of therapy currently relate rather to the quality of the consent given than to the nature of the therapy itself. The essence of the problem, then, relates to whether or not the doctor can take advantage of the maxim volenti non fit injuria[19] - that is, one cannot successfully claim damages where there has been a voluntary assumption of risk of the kind of happening which subsequently eventuates. In order for this plea to be successful, it is necessary that the risk was both known and accepted. This involves both information disclosure and acceptance of risk. A person cannot be said to have voluntarily accepted a risk if he or she was unaware of the possibility of the risk actually occurring. As Scott, L.J. said in Bowater v. Rowley Regis BC[20]:

> In regard to the doctrine volenti non fit injuria, I would add one reflection of a general kind. That general maxim has to be applied with especially careful regard to the varying facts of human affairs and human nature in any particular case, just because it is concerned with the intangible factors of mind and will. For the purpose of the rule, if it be a rule, a man cannot be said to be truly "willing" unless he is in a position to choose freely; and freedom of choice predicates, not only full knowledge of the circumstances upon which the exercise of choice is conditioned, in order that he may be able to choose wisely, but the absence

> from his mind of any feeling of constraint, in order that nothing shall interfere with the freedom of his will.[21]

The voluntariness of acceptance of risk can, in the case of the patient, be dealt with first. It is clear that, in many cases, the patient who accepts therapy does so not entirely free from some kind of duress. This pressure, however, stems not necessarily from the doctor, but more importantly (and perhaps unavoidably) from the illness itself. Patients may, for example, fear surgery, and may certainly prefer not to undertake it in normal circumstances, but the need for surgery is the result of illness, and therefore something to which they will generally give consent. Although the voluntariness of consent may, therefore, be theoretically more questionable than in a less threatening situation, it would make a nonsense of medical practice and health care in general were it to be suggested that it should not satisfy the volens requirement. Indeed, disputes about the quality of consent centre primarily on the sciens aspect - that is on whether or not the patient actually was sufficiently knowledgeable about the risks to offer meaningful or valid consent.

## Information

In relation to this it is obviously necessary that information is disclosed on which the patient can base his or her decision. Relevant information about known risks (and benefits) must form a substantial part of ensuring that the patient is in a position to accept (or, on the contrary, reject) therapy, and it is the provision of this information which renders the subsequent therapy both morally justified and legally protected. This aspect of the interaction of doctor and patient, therefore, is substantially what is the issue when a reference is made to 'informed' consent. As Robertson says

> ...the doctrine of informed consent is a legal concept which imposes a duty on the doctor to explain to his patient, not only the nature of the proposed treatment, but also the dangers and risks inherent therein.[22]

By the making of such disclosure, the patient is placed in the position to offer a meaningful and real consent, and to become an active participant in choices about his or her health care. The duty to make such disclosure is placed on the doctor because he or she is, by the nature of his or her professional skills, in possession the of relevant information. But this does not minimise the input of the would be autonomous patient, and demands that '[m]edical personnel are not justified in substituting their best medical judgments for patients' informed decisions.'[23] A commitment to patient participation, however, does not answer the question as to the extent of information which must be disclosed.

If information disclosure is genuinely to protect patient autonomy, then obviously <u>all</u> relevant information should be disclosed. Thus, every known risk - whatever its statistical probability - should be made known to the patient, since every risk might have a significant effect on that individual. Equally, every known benefit should be made known. Of course, doctors are not, as has been seen, legally liable in negligence for failing to keep abreast of developments even in their own field, although best practice might suggest that they should do so.[24] The impractibility of so doing, however, makes it sensible and fair not to require total knowledge of every conceivable article, book, and so on, which could be relevant. This is not to say that doctors need not follow the major articles and reports in respect of their disciplines, but it is reasonable that they should not be expected to go to ridiculous lengths. This, of course, will obviously have an impact on their knowledge of the nature and the range of risks which are attached to a given procedure, and which they can, therefore, disclose to their patients.

All therapies contain some risks. For example, there is a risk of allergic or idiosyncratic reaction to all drugs. Equally, every anaesthetic carries a risk, to say nothing of the risks inherent in surgery itself. Some risks may reasonably be thought to be within the knowledge of every physician - for example, the small risk of death under general anaesthetic - but others will be more specifically related to the individual selected form of therapy. If the doctor is not legally or professionally bound to keep totally up-to-date with his or her specialism, then reasonably also, he or she will not necessarily be expected to be aware of every conceivable risk inherent in every possible therapy. To some extent, therefore, the amount of disclosure which should or can be made will initially be limited by the knowledge of the individual doctor.

If patient autonomy is adequately to be protected, however, then there must be a standard which facilitates that autonomy - that is the standard for disclosure should be set by courts with patient autonomy to the fore. This, if taken to its logical conclusion, would require two distinct types of information disclosure.

## Disclosure of Therapeutic Alternatives

As has been seen, doctors exercise their professional skills both in diagnosis and in selecting appropriate therapy. However, in some - perhaps many - situations there are alternatives in therapy, each carrying their own risks and their own benefits. Patient autonomy is as importantly protected by the capacity to participate in knowing choices about the type of therapy, as it is by having the capacity to decide whether or not to accept the recommended therapy. This is not to suggest that the patient has the technical skills to know the available choices, but merely, and more reasonably, to indicate that where alternatives exist the patient must be put in a position to evaluate the relative risks and benefits of these choices. As has been said, '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.'[25] It is not inconceivable that a patient may be prepared to accept the risks associated with one therapeutic option but not with another. This is because:

> In many circumstances patients can make adequate choices about medical treatment only when they consider non-medical benefits and harms in addition to the medical benefits and harms which may accrue from these choices.[26]

The availability of therapeutic alternatives is a not uncommon feature of medical practice. Moreover, doctors themselves may differ on diagnosis and appropriate therapy. As was noted in the case of Hunter v. Hanley, '[i]n the realm of diagnosis and treatment there is ample scope for genuine difference of opinion.'[27] If patient autonomy is to be offered adequate protection, however, it is for the patient - of course on medical advice - to select the therapy most suited to their emotional, personal or financial situation. When the law protects this freedom it offers more than a mere theoretical commitment to autonomy. However, in both the United States and the United Kingdom, concern has been expressed that such an attitude is not common, or at least not routine. As Shultz put it:

> The law's response to pressures for a greater recognition of patient autonomy has been ambivalent. Existing rules repudiate the view that the mere hiring of a doctor transfers all authority from patient to doctor. Yet full vindication of patient autonomy interests would necessitate placing final authority regarding important decisions in the hand of any patient, having the capacity and the desire to exercise it.[28]

Equally, in the United Kingdom, this 'vindication of patient autonomy' has not always been obvious in situations which involve therapeutic choice. The most notable example of this can be found in the case of Hatcher v. Black.[29] In this case a doctor diagnosed a thyroid complaint, a condition susceptible to treatment either by drug or surgical therapy. Each of these therapies involved its own distinct risks, but in addition to the risks, the therapeutic benefits differed. In the case of drug therapy, it was the opinion of the doctor that, if successful, its success would be less be that of successful surgery. Accordingly, he selected surgery as the right medical option, and failed to inform his patient of the existence of an alternative. This denial of therapeutic option was not criticised by the court, on the grounds of professional judgement. Yet denial of the opportunity to make therapeutic choices is as autonomy reducing as is any other denial of information.

## Disclosure of Risks and Benefits

It is not common for doctors to minimise the potential benefits of therapy, but it is equally not common for them to emphasise the risks. What has been called the 'therapeutic imperative' dictates much of medical practice. If medicine has a potential cure, then it makes medical sense to use the appropriate therapy in order to effect that cure, and not to deter the patient by explaining the potential risks. At a purely professional level, it may be rational to view the desirability of information disclosure in this way, but in terms of patient autonomy it can only be denounced as paternalism. As has been seen earlier,[30] the reasons often given for not disclosing risks can be defeated when the professional standard is given less than optimum weight and consideration. If patient autonomy is crucial, then even information which prevents therapy must be disclosed. In other words, account must be taken of the fact that, for patient autonomy to be adequately protected, there must a standard set not by medicine but by a legal system concerned about patients' rights to make choices in therapeutic encounters.

On the strict autonomy model then, all risks - and not merely some of them - must be disclosed if the patient is to be free to make personalised and meaningful decisions. That this is not common practice will be seen in more detail below, but for the moment there is one further consideration which follows from this claim. It is routine for courts and doctors to adopt a form of assessment of medical behaviour which equates to the kind of paternalism described, for example, by Buchanan.[31] Even where it is accepted in principle that risks should be disclosed, a further refinement is often used which minimises the nature of the risks themselves. Thus, it may be said that 'real' or 'material' or 'substantial' risks should be disclosed, but that by implication, those risks which do not fit into these categories need not be. Of course, if this is to be an acceptable modification of patient autonomy, it is necessary to formulate a test for 'realness' and so on. The materiality of a risk, it seems to be assumed, depends on the medically definable and determinable characteristics of the risk. If this were not so, then the patient would have to be informed of each risk in order that he or she could decide on whether or not it actually <u>was</u> real or material. Thus, the choice of risks to be disclosed remains very much the province of the doctor. But what implications does this have?

Clearly, since the physician in most cases will not also be the patient, it is necessary for the doctor to make calculations about the materiality of the risk, and this can only be done in a limited number of ways, none of which are satisfactory for the vindication of patient autonomy. On the one hand, the doctor may decide that his or her knowledge of the patient is sufficient for a decision to be made that only certain risks actually matter. This is open to objection on the very obvious ground that the doctor can never know the full facts of the patient's life, nor what values the patient places on certain aspects of that life.[32] This kind of assessment, therefore, amounts to little more than guesswork, and is unacceptable to those who have knowledgeable decision-making as a goal.

Equally problematic, but less open to allegations of the casual importation of uninformed value judgement, is the use of scientifically known or knowable fact. A given therapy, for example, may be known to have a 5% risk of causing a skin rash, a 1% risk of causing severe headache and a 0.2% risk of causing paralysis or death. There are two possible 'scientific' ways of approaching this range of possible effects. One, and the most obvious, is to use statistical method and to consider as substantial only that which is statistically significant. On this form of calculation, the patient would be informed of the two greatest risks, but not of the smallest statistical one. In terms of patient autonomy, this is obviously unsatisfactory since it omits to provide the patient with some information, and, in particular, information which might seem to the patient to be the most significant - that is the small, but nonetheless real, chance of paralysis or death. Using this approach then, the patient is denied access to information which may be vital in the decision whether or not to accept therapy. Of course, the standard arguments about unnecessarily frightening patients, or possibly deterring patients from accepting therapy, could be, and are, used to explain the making of such a choice, but for the reasons discussed above, they scarcely justify it.[33] It is not irrational for people to attempt to avoid even a very small risk of possible death, and indeed in wearing seat belts or minimised flying time, many people do this routinely.

The alternative use of the statistical probability equation is equally open to objection. This approach could suggest that only the gravest of possible risks should be disclosed. In this calculation, the patient would be told of the small risk of paralysis or death, but not necessarily of the possibility of headache or skin rash. Whilst this is equally autonomy-reducing, it has one further possible side effect which can have a major impact on patient care. That is, the patient who is unaware that these are possibilities may suffer considerable distress, and require further medical time, if he or she is not aware that what is happening is a result of the current therapy and not a manifestation of a new and unpleasant illness. Patient care is, it has been claimed, enhanced by respect for the patient, and this simple example serves to show one situation in which that conclusion is validated.

Thus, it can be concluded that patient autonomy is only protected where there is a meaningful choice made by the patient, on the basis of adequate information, about which of the available therapies is acceptable and as to whether or not to participate in any therapy at all. Disclosure of risks and benefits protects not only the patient but also the doctor. No subsequent allegation of a lack of real consent can succeed where the doctor has respected his or her patient sufficiently to make such a disclosure, and to discuss the implications of accepting or rejecting therapy with the patient. This latter point is also highly significant, since it must be remembered that advocates of full disclosure do not simply advocate disclosure of risk. It is equally essential that the patient is given access to information about potential benefits, in order to permit the making of a choice which takes account of these competing factors. When this is borne in mind, fears that patients will routinely reject therapy become not merely insulting to the common sense of patients, but minimised considerably.

## Patient Understanding

There remains, however, one considerable problem - one argument for the paternalistic model of medicine which could be more problematic to dispose of. It may be claimed that, since patients cannot understand highly technical information, the provision of that information is a meaningless and time-consuming farce. If the rationale for information disclosure is to enable the patient to make a knowing (albeit not necessarily a 'rational') choice, then what, it might be asked, is the value of disclosure without understanding? And if the patient does indeed lack the technical skills him or herself to undertake the medical enterprise, then how could he or she truly understand the information? If such understanding is indeed impossible, then what is the point in making the disclosure? And, could it ever be reasonable to make the doctor subject to a duty to ensure patient understanding, because, if not, then surely information could be disclosed in highly technical terms which would render the patient no more capable of making a knowing choice, and therefore in no better a position to protect his or her autonomy?

These questions were formally, and it is submitted appropriately, answered in Canterbury v. Spence,[34] and the answers given there serve to explain why it is that the emphasis in this discussion has been on the duty to disclose, rather than on 'informed consent'. As the court said:

> In duty to disclose cases, the focus of attention is more properly on the nature and content of the physician's divulgence than the patient's understanding and consent. Adequate disclosure and informed consent are, of course, two sides of the same coin. The former is a *sine qua non* of the latter. But the vital enquiry on duty to disclose relates to the physician's performance of an obligation, while one of the difficulties with analysis in terms of 'informed consent' is its tendency to imply that what is

> decisive is the degree of the patient's comprehension.[35]

Thus the duty to disclose, when based on the patient's right to receive information, can be tested independently of patient understanding, however desirable that understanding may be. The doctor fulfils his or her obligation by making the disclosure in a reasonable way, so as to facilitate patient understanding, even given that it cannot be guaranteed. As the court further said, '...the physician discharges the duty when he makes a reasonable effort to convey sufficient information, although the patient, without fault of the physician, may not fully grasp it.'[36] In any event, the problems perceived in patient understanding may be overstated since it is not the technicalities of drug action or surgical technique which alone constitute information which is autonomy-enhancing, although some patients may be sufficiently interested to want to know about these also. It is the risk of hair loss, or voice loss, or other disability which concerns the average patient, and not the mechanics of the therapy, except where these are inseparable from the risk itself. Nor, of course, is the doctor obliged to inform the patient that there is a risk that he or she might perform the therapy in a negligent manner.[37]

This is not to say, however, that the question of patient understanding is totally irrelevant. Some writers, indeed, whilst insisting on the necessity of information disclosure, equally maintain that disclosure without understanding is useless and merely a parody of patient involvement. For example, Robertson[38] has said that:

> The doctrine of informed consent can only become meaningful in terms of the patient's right to self-determination if he actually comprehends the information which is disclosed to him - without such comprehension the patient is not given the opportunity which he requires, in order to make a rational decision. Even accepting that the patient's right to self-determination dictates only that he be given a <u>reasonable</u> opportunity of making a rational decision as to proposed medical treatment, the extent of the patient's comprehension of the disclosed information should still be a vital issue. The opportunity given may be 'reasonable' if viewed from the standpoint of the doctor, in terms of the information which he has disclosed, but that opportunity becomes wholly unreasonable for the purpose for which it is given and completely meaningless, if viewed from the patient's standpoint if he fails to understand the information given to him.[39]

This emphasis on patient understanding is not, however, shared by all commentators. The act of disclosure is itself seen by some as adequately protecting patient autonomy, particularly where the disclosure is couched in terms which the average patient could understand. Indeed, with due respect to Robertson, it might be said that he falls into two of the traps which medical paternalism also does. First, he makes the assumption that information which should be disclosed is difficult information - almost certainly because it is technical.

It is not clear, however, that this is in fact the case. Certainly, the patient consults the doctor because the doctor possesses technical skills, but the impact of the exercise of these skills is not solely to bring about a technical result. Rather, it effects a cure, brings relief or, in unfortunate cases, causes harm. None of these are technical matters, as experienced by the patient, although they may be brought about by the exercise of technical skills.

If this is accepted, then the second fallacy in this type of argument becomes clear - namely, that the average patient cannot understand the information which is in fact relevant to him or her - that he or she may or will recover, that the best that will be done is to relieve discomfort, or that there may be some harmful side effects of treatment. In other words, what renders the standard patient competent to give consent is the fact that he or she can understand (given the information) the likely personal impact of his or her choice. If Robertson's argument were to be pursued to its logical conclusion, and only those who could understand the technical impact of therapy were able to give real consent, then no one, bar a doctor in the same specialism and at an equal or superior level of skill, could legally offer a meaningful consent. This is a reductio ad absurdum of the whole context in which consent is considered.

Robertson's view that, in the American courts at least:

> ... the doctrine of informed consent is a legal mechanism whose function has simply been to expand the liability of the medical profession, in order to compensate a greater number of victims of medical accident.[40]

is doubtless valid, but this does not detract from the symbolic, the practical or the moral position which demands that such consent is in fact provided. Even if the desire to expand liability has become a highly significant rationale for the use of the doctrine in the United States, or indeed in other jurisdictions, it cannot be totally separated from issues of patient autonomy. The desire to expand liability, therefore, merely indicates legal recognition of the value of the interests at stake.

This is not, of course, to minimise Robertson's excellent consideration of the consent question, and in particular it is not to underestimate the problems which patient comprehension can pose to the autonomy theorist. The technical gap between doctor and patient is great and even non-technical information may be misunderstood by patients. Finding a way of evaluating patient understanding is, however, unlikely. Certainly, the patient could sit an examination based on what he or she was told but this is merely ludicrous. In any event, not even the autonomy theorist would want to place a duty on the doctor to <u>ensure</u> understanding, since, logically, failure in this duty (for reasons which could relate to the patient and not the doctor) would result in the possibility of a law suit against the doctor solely because of the patient's incapacity. Clearly this is not to be taken seriously.

However, the duty to disclose information can be seen as one which should be exercised in a professional manner - professional, that is, in the broadest sense. Most professionals are routinely faced with the problem of ensuring client understanding, and this can be, in many, if not most, situations, achieved by explanation which avoids technical jargon, and by providing the relevant information in a relatively stress-free setting. Of course, the doctor will usually be dealing with a situation which does involve stress, but this does not excuse him or her from seeking to achieve the standard of professional behaviour which it is reasonable to expect from any group possessing special skills. The transmission of information is a vital aspect of much professional practice, and can and should be done sensitively and with due regard to the information gap between any professional and any client.

There remains, however, one further problem concerning patient autonomy as described by Robertson,[41] and that is the apparent significance which he gives to rational decision-making. Dependence on rationality may open the door to yet further tests of the efficacy and desirability of information disclosure, which again resemble to some extent the reasons sometimes presented for non-disclosure by the professions themselves.[42] Whilst it is true that the patient requires information which <u>permits</u> him or her to make a rational decision, it is not clear that the <u>making</u> of a rational decision is the delimitation of his or her rights to autonomy or self-determination, nor that the rationality or otherwise of the decision should be used as a yardstick against which the merit of disclosure can be tested. Except in situations where there is a clear risk to others involved in patient decision-making, it is not, in the first place, clear that self-determination is intimately connected with making rational choices. Indeed it is plausible to argue that the right to self-determination necessarily includes the right to act irrationally. Moreover, the concept of rationality is in itself problematic, and may be particularly so in the case of decisions about therapy.

The decision as to what is a rational choice in this situation, as in others, is seldom value-free. In the abstract, it may be thought to be rational to choose possible or probable cure over continued ill health. But where this choice involves the acceptance of therapy, its rationality may be challengeable. It has been claimed, for example, that a substantial proportion of all illness is self-limiting.[43] In other words, a large percentage of complaints for which people consult doctors would go away if left alone. Many of the most common reasons for consultation are widely believed to be susceptible to environmental or other change (that is to be capable of political or non-scientific resolution).[44] In these terms, it may be rational not merely to avoid therapy, but, given the inevitable risks of many diagnostic techniques and therapies, to avoid treatment altogether - at least in these cases. Of course, this is a rather extreme position and not one which most people would recommend, but it serves to highlight one of the potential variations on rationality which should command some consideration.

More serious consideration may, however, be merited in respect of the rationality question, where the choice taken is to prefer illness to therapy, even where the therapy is known to have a reasonable or certain chance of success. In this situation, rationality could be viewed in two distinct ways. Where cure is possible, probable or certain, it might be said to be rational to accept the therapy. Thus, it could be argued, there is no purpose served, and indeed harm may be caused to the patient, by disclosing the inevitable risks of that therapy. It is not, in this view, in the interests of patient care to distress the patient so that therapy is rejected or to emphasise the risk factor with the same possible outcome. This view has received considerable judicial backing notably in the case of Bolam v. Friern Hospital Management Committee,[45] where McNair, J made the following remarks to the jury:

> Members of the jury, although it is a matter entirely for you, you may well think that when dealing with a mentally sick man and having a strong belief that his only hope of cure is ECT treatment, a doctor cannot be criticised if he does not stress the dangers which he believes to be minimal involved in that treatment.[46]

Although this case involved a patient whose mental health was unstable, there was no suggestion that he did not have the legal capacity to consent. What was in dispute was whether or not a warning as to the existence of specific risks (which were known, albeit unusual) should have been given. Here, the judge chose to believe (as did the jury) that the statistical improbability of the risk occurring minimised any duty to make disclosure, but the decision also shows the extent to which the therapeutic imperative (and the rationality of accepting treatment) was given credence. The fact that the therapy was seen <u>medically</u> as a viable and good option, invested it with a level of credibility which apparently overrode the patient's right to know. The second possible interpretation can be seen here also - that is, that it is rational to accept medical decisions about the appropriateness of therapy.

The view that accepting medically recommended treatment is the rational decision, often sits uneasily with the desire to maximise patient autonomy. What is medically rational may be personally irrational. The only person in the doctor/patient relationship who can, in fact, determine what is rational is the person in possession of the totality of personal details - that is the patient. As Shultz[47] says:

> Medical choice increasingly depends on factors that transcend professional training and knowledge. As medicine has become able to extend life, delay and redefine death, harvest and transplant organs, correct abnormality within the womb, enable artificial reproduction and trace genetic defect, questions about values have come to the fore in medical decision-making. Health care choices involve profound questions that are not finally referable to professional expertise.[48]

This leads to the fundamental question as to what it is that truly characterises that aspect of the doctor/patient relationship which relates to disclosure of information and the provision or withholding of consent. Few would doubt that much of what is characteristic of the doctor/patient relationship is the use of professional (technical) skills, nor that the exercise of these skills should seldom, if ever, be circumscribed by non-professionals. The decision as to whether this or that antibiotic is specific to this or that particular infection is scarcely one which courts are qualified to make or to judge. Equally, the mere fact that one doctor may legitimately prefer one to the other on technical grounds is not in dispute. These matters relate to professional competence and the level of technical information possessed by the skilled practitioner. As Giesen[49] puts it:

> The determination of the standards of medical science may ..... be difficult. Medical science is (as any science) characterised by some scientific controversies. It must be emphasised in this context that the lawyer (and especially the judge) cannot and must not presume to decide controversies of medical science. In such cases, especially, the courts can do nothing other than act in accordance with the practical experiences of the medical profession, rather than with the theoretical and dogmatic arguments put forward by this or another school.[50]

Thus, courts cannot presume to know, where different opinions on technical matters are competently held, or scientifically justified, which school of medical thought is the appropriate or correct one. However, it does not follow that a court cannot decide that this or that particular practice has failed to meet the legally required duty of care.

More important, however, for the purposes of this discussion, is the question whether - even accepting the above statement of the law's role - what is being dealt with in controversies over information disclosure and consent is in fact a technical question at all. On the answer to this question hinges both the relevant legal machinery and the very form of decision-making itself.

## What is Consent?

From the outset, it has been claimed here that the rules about consent which exist in developed legal systems are rules designed to perform a specific purpose. That purpose is to permit the patient the continued exercise of self-determination or autonomy. Whereas illness may be autonomy reducing - and this is particularly the case in certain types of ill health[51] - autonomous choices can also be made within the context of the patient's interaction with medicine. It has also been suggested that the doctor's duty to obtain the consent of his or her patient is a duty which derives from the patient's right. The delineation of that duty therefore is dependent on recognition of, and respect for, such a right.

To this extent, therefore, the duty to obtain consent is one which transcends the doctor's professional (technical) expertise. Its boundaries cannot be drawn solely by reference to this expertise, although it is its possession which puts the doctor in the situation whereby he or she is under the duty in question. But the duty is not dependent exclusively on technical skills, although it may have some link with them. Rather, the duty - its nature and content - is specifically correlated to the right from which it derives. To put it another way, there is a very real question as to whether or not the duty can be defined without first establishing the corresponding right. As Skegg, for example, has said:

> There is nothing especially 'medical' about the requirement that a doctor must obtain a patient's consent ...... These requirements are imposed not in the interests of the

> patient's health, but in the interests of individual liberty.[52]

It is important, therefore, that this crucial distinction between the types of duties which doctors owe to their patients is borne in mind. On the one hand, there is the set of technical duties, described above, and on the other there is the moral or ethical (but also legal) duty which demands information disclosure, defined not by the amount of information which the doctor thinks the patient should know, could handle or might want to know, but by the amount of information which the patient needs to have in order that the making of an autonomous choice is possible. The role of law in our society makes the legal process the commonest and most effective mechanism for providing such definition - for filling out the qualities of the duty owed and protecting the patient whose rights are breached. As has been said in a number of cases this requires a standard for disclosure which is set by law and not by professionals.[53] This implicit recognition of the significance of the right under consideration lends weight to the claim that in considering questions of consent, what is in issue is something more valuable, and certainly more difficult to define, than a professionally given assessment of the technical manner in which acquired skills should have been, or were actually, used.

Moreover, it has been central to this discussion that the law can perform two major functions in offering or withholding such protection. First, the law can make available a form of action appropriate to the provision of redress, and second it can adopt a disinterested stance in the protection of the patient, by setting standards which reflect the source of the action. It has already been claimed that - however sound the reasoning - the shift from the assault-based action to the negligence action has substantially limited the availability of redress for invasion of bodily or mental integrity, and may also have served to obfuscate the issue under consideration. The difficulties of proof which characterise the negligence action, and the requirement that measurable harm was caused, coupled with the need to establish causation, have been shown to raise fairly major hurdles to a successful action. This is particularly so in medical cases, not only because of conservative judicial decision-making, but also because of preconceptions about the value of therapy and the logic of accepting treatment which evidently pervade much of judicial, and indeed societal, thinking. The potential impact of these factors should not be underestimated. As Harris[54] says:

> If individual and collective freedoms and genuine equality between sections of the population are to be pressed for and protected, then the law has an important part to play. Its use as an ideological weapon must be exposed, but its force as a limitation upon power must be recognized.[55]

However, despite the problems associated with the form of action now deemed appropriate, flexibility of decision-making remains possible.[56] But this is only true where the courts are constantly reminded of the rationale for consent rules and where the distinction between technical medical questions and autonomy enhancing practice is remembered. Thus, the use of the negligence action in cases involving disputes about the provision or quality of consent, requires consideration, if its efficacy in these cases is to be assessed. In reviewing these cases, it seems to make sense to begin with a consideration of the approach which has been adopted in the United States, where the doctrine of 'informed consent' originated and is widely believed to have been most thoroughly developed, before turning to consideration of the application of consent roles in the British context.

## Development of Consent Doctrines - U S A

The rules governing the negligence action in both the U.S.A. and the United Kingdom are developed from roughly similar legal traditions and not surprisingly, therefore, tend to be parallel. Yet, United States courts have occasionally shown a more aggressive stance in cases which they see as involving issues of fundamental values and rights. It is scarcely surprising, then, that American jurisprudence seems to have been more overtly concerned with patient choice - hence the development of what has come to be called 'informed consent'.[57] However, there are interpretational problems in the use of the word 'informed' which can make it a less than satisfactory qualification of consent. Thus, throughout this discussion, the writer will prefer the terminology of 'real' or 'meaningful' consent based on information disclosure - disclosure primarily of risk but including disclosure of potential benefits. The latter of these is in any event uncontroversially a routine part of medical treatment and consultation. It is, therefore, with the former - that is disclosure of risks - that this section is primarily concerned.

The classic statement in Schloendorff[58] as early as 1914 demonstrates the concern which American courts have shown for issues of personal autonomy. At a theoretical level, it is the case that all developed jurisdictions share this concern, but it is also crucial that the retoric of rights-protection is translated into the reality of securing those rights. As Shultz notes:

> Individuality and autonomy have long been central values in Anglo-American society and law. In general, the more intense and personal the consequences of the choice and the less direct or significant the impact of that choice upon others, the more compelling the claim to autonomy in the making of a given decision. Under this criterion, the case for respecting patient autonomy and decisions about health and bodily fate is very strong.[59]

In 1918, in the case of Hunter v. Burroughs,[60] the court made it clear that the doctor has a duty 'in the exercise of ordinary care to warn a patient of the danger of possible bad consequences of using a remedy.'[61] As concern about patient autonomy grew, and as doctors became more frequent subjects of challenge in the courts, these somewhat loose and ill-defined statements became more closely defined, and the shape of what was to become the doctrine of consent became more clear. Perhaps the most significant case at this early stage was the case of Salgo v. Leland Stanford[62] in which possibly the first real attempt was made to outline the scope of the doctrine. As the court said:

> A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment.[63]

From this innovative statement, however, are also apparent some of the difficulties of the use of 'informed' as legally accepted terminology in deciding on the validity of a given consent.

If 'informed' is to be used in constant conjunction with consent, then it must have a meaning relevant to the description of a legally acceptable consent. 'Informed', of course, could be said only to imply that information has been given and received. However, implicit in the above judgement is a further qualification which merits consideration as it is inherent, apparently, in the entire doctrine of 'informed consent', and renders this straightforward assumption less easily tenable.

The court, by phrasing the doctrine in this way, left the door wide open for the kind of interpretation which has, in fact, subsequently proved to be problematic for the aggrieved patient. 'Informed consent' depends on disclosure of information which enables a patient to make an 'intelligent' choice, not simply to make a choice. However, what *are* those facts which are necessary to make an 'intelligent' decision? What indeed, *is* an 'intelligent' decision? In effect, the court described what seemed to be a set of conditions for safeguarding patient autonomy, but additionally gave a hostage to fortune by countenancing, not full disclosure, but rather disclosure which facilitates an 'intelligent' choice. This could readily be taken to infer that the quality of the disclosure will, at least in part, be implied from the quality of the decision. Given what has already been said about the rationality of patient choice, it may, then, be arguable that an 'intelligent' choice is one approved by physicians. If this interpretation is adopted, then doctors would not be liable for failing to disclose information which would prevent acceptance of therapy. In other words, a decision on the questions posed above could be taken by reference to the views of the physician, subject only to the *caveat* that a duty to disclose does exist. However, it would be well to bear in mind that '[e]xperts may blind themselves by expertise. The courts should protect the citizen against risks which professional men and others may ignore.'[64]

This case is also atypical in that the court's view was that failure to obtain informed consent rendered the doctor liable in trespass rather than negligence. In Natanson v. Kline [65] (1960) the court reaffirmed the duty of the physician to make reasonable disclosure of risks, but regarded the decision as to whether or not disclosure was reasonable as one to be taken within the negligence framework. The shift to the negligence action has already been described as one which de-emphasises patient autonomy. However, it is at least logical for the court to accept a substantial, or at least important, medical input into the decision as to what and whether to disclose when the case is decided on the basis of reference to medical duties, and only tangentially on the question of patient's rights. The shift to the negligence action, therefore, can be seen as having the almost inevitable (and certainly logical) consequence of moving the focus of interest from patient autonomy to the standards accepted in medical practice.

These cases, however, were landmark decisions in the development of disclosure rules. Not only did they herald legal concern about consent in medicine, but they also profferred both a definition (of a sort) of what consent rules should be, and a statement as to the appropriate form of action. This had wide reaching consequences, not only for the nature of the proof required for a successful action, but also for the types of evidence which could decide the case. That is, placing information disclosure firmly within the negligence framework emphasised that the crucial question is whether or not a doctor has failed in a duty (which his or her colleagues have a role in defining) - thus shifting the ultimate responsibility for therapeutic decisions from the competent patient, and placing some (occasionally major) decision-making control firmly in the hands of the doctor.

Emerging from these cases also is what has come to be called the 'reasonable doctor' standard, or the professional test for negligence. In other words, the 'realness' or validity of apparent consent depends not on what the instant patient claims to have wanted to know, but rather on whether or not physicians regard the failure to disclose a given piece of information as having been professionally reasonable. Inevitably, therefore, this places the definition of 'reasonableness' for these purposes firmly within the framework of professional assessment, and renders the court's ultimate function of deciding on whether or not it actually was reasonable, vulnerable to medical pressure. Thus, unlike the common sense view which can be taken of the 'reasonable man', courts must weigh heavily medical evidence of current practice in deciding what the reasonable doctor would have done or what he or she should be held liable for. Policy considerations, described above,[66] are therefore as likely to be imported into the area of information disclosure as they are into technical issues in medical behaviour. The courts in the United States were, at this stage, unwilling to make a distinction between the technical and the moral aspects of medical behaviour. Unwilling, therefore, to consider information disclosure as more than - perhaps even distinct from - the doctor's general professional duty of care to the patient.

The 'reasonable doctor' test received considerable support over the next few years and indeed continues to be the standard used in most American States.[67] However, the issue did not die there and other courts were prepared to reconsider this formulation of the appropriate values and interests involved in information disclosure. The most significant of these cases was the landmark decision in Canterbury v. Spence [68]in 1972. In this case, the court addressed itself to the rationale for disclosure rules and in so doing placed considerable emphasis on the right of the patient to receive information - a right which admittedly could only be satisfied by the doctor fulfilling a correlative duty to make that disclosure, but one, nonetheless, which generated, rather than was subordinate to, the duty. In so doing, the court distinguished neatly between these aspects of medical practice which are called technical and those which are not. As the court said:

> The context in which the duty of risk disclosure arises is invariably the occasion for the decision as to whether a particular treatment procedure is to be undertaken. To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie. To enable the patient to chart his course understandably, some familiarity with the therapeutic alternatives and their hazards becomes essential.[69]

At first sight, the decision in Canterbury seems to redress the balance in favour of patient's rights. By making the distinction between medical practice and the moral nature of the medical enterprise, they moved towards the very basis of consent rules and requirements about information disclosure. Indeed, the court explicitly acknowledged this distinction by indicating that interests other than the purely medical are intimately connected with the ultimate assessment of liability. As the court put it:

> We agree that the physician's non-compliance with the professional custom to reveal, like any other departure from prevailing medical practice, may give rise to liability to the patient. We do not agree that the patient's cause of action is dependent upon the existence and non-performance of a relevant professional tradition.[70]

Thus, although medical evidence as to standard practice is informative, it need not be regarded by the court as being definitive of good or acceptable practice. Indeed, without adopting an aggressive position, the court made clear its concern that such should not be the case, seeing 'formidable obstacles to acceptance of the notion that the physician's obligation to disclose is either germinated or limited by medical practice'.[71]

But what are these obstacles, if they do not indicate that what is being dealt with is an issue bigger than medical choice about the need for, and type of, therapy? If the therapeutic imperative is not to be dominant, on what grounds is this so? Quite simply, the overriding value of therapy - whilst it may be agreed upon by the medical world - is not, and cannot be, the most significant characteristic in disputes about non-disclosure, if such disclosure is required as a means of safeguarding the rights of patients - rights which go beyond the fact of illness, alleviation of symptoms, or even potential or probable cure. What is significant is the right of the patient to autonomy and this right is one which is not minimised in the standard medical interaction, nor is it one which can be described by physicians themselves. As the court said, '[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law rather than one which physicians may or may not impose upon themselves.'[72] This was not intended either to devalue therapy or to criticise medical practitioners, but rather to demonstrate the significance of the values to be protected by information disclosure - values which the law reserves the right to assess, and has the ultimate duty to secure.

Thus far, the court seemed to be unequivocally interested in patients' rights, albeit within the context of negligence analysis. This reference to patient autonomy as the fundamental value in non-disclosure cases has been echoed in a number of subsequent decisions, although it has not routinely formed the basis of decisions in many American States, nor in other countries throughout the world.[73] Indeed, despite a plea for acceptance of the <u>Canterbury Test</u> by Lord Scarman in <u>Sidaway</u>,[74] it remains by no means the standard test used. This is so despite the manifest philosophical problems in the 'prudent doctor' test.

In fact, however, the <u>Canterbury</u> case itself showed unfortunate equivocation, resembling that seen in the 'reasonable doctor' test. The court continued to emphasise the significance of choice-making by the patient but was forced to confirm the difficulties inherent in deciding how this could be protected. At first sight, it might seem logical that the emphasis on self-determination so evident in this case, would inevitably lead to the conclusion that all information which is within the knowledge of the doctor should be disclosed to the patient. At a theoretical level, it would seem that only in this way can the patient's autonomy actually be protected. Each possible risk, however, slight - statistically or in terms of its consequences - might be valued by a patient in a way quite distinct from the weight accorded to it by a doctor or a court. This the court accepted.[75] However, there were further considerations taken to be significant, not least the role of the law itself. The court was faced with the task of formulating a definition of consent which was 'informed' or real but which permitted cooperation rather than confrontation between the doctor and the law. Indeed, the judgement ab initio shows marginal ambivalence to the issue of patients' rights to information disclosure - an ambivalence which is central to the standard ultimately formulated.

A number of factors seem to have contributed to this. Much concern, for example, has been expressed about the extent to which the liability of physicians would be expanded were the patient able to claim that the omission of any one piece of information resulted in liability to the patient. Patients, it has been suggested, could thereby give vent to their understandable disappointment, or even bitterness, where their contact with medicine goes wrong. Naturally, it is said, the patient will complain when something bad happens, but this cannot, it is contended, be given ultimate credence.[76] It was in this respect that the court ran up against its most significant difficulty in formulating an appropriate standard. On the one hand, in repudiating the professional test, the court placed considerable emphasis on the rights of the patient. On the other, however, too severe a standard would place the entire practice of medicine at risk, by denying clinical freedom and generating excessive litigation.

Moreover, it was clear that problems could arise in settling appropriately and satisfactorily the question of causation. As has been said, where the appropriate basis of the action is negligence, it is necessary not only to decide what the duty owed actually was, and whether or not it was breached, but it must also be shown that the breach caused harm. In allegations that information disclosure was not adequate this may be problematic. The patient may be aggrieved if all information is not disclosed, on grounds which sit uncomfortably within the negligence framework or which are not compensable in negligence analysis. He or she may feel that his or her right to self-determination was shown insufficient respect where a risk was concealed, even if that risk does not actually occur. Thus, despite the fact that damages for invasion of personal integrity might be relatively small, nonetheless, the patient may feel that he or she should be entitled to register a complaint through the court process, and that he or she would be justified in obtaining some compensation for the unwarranted assumption of authority over integrity.

However, there are limitations on the type of damage which is legally recognised, and this may pose considerable problems for the patient.[77] Further, there is a problem in squaring respect for human rights with what it is that the negligence action is designed to achieve. Even where it is accepted that the basis of disclosure rules is the patient's right to self-determination, the very nature of the negligence action demands some form of rationalisation. The action is ill-designed to cater for the immediate concerns of the individual, since the ultimate determination of whether or not there is negligence rests, not on theoretical considerations, but on an assessment of the extent or the manner in which <u>duties</u> were carried out.

Despite this court's concession that the provision of information about risks was something wider than the merely technical, courts have long failed to make this distinction. Consider, for example, the views of Mr. Justice Woodhouse in the case of <u>Smith</u> v. <u>Auckland Hospital Board</u>.[78]

> If the issue in the case was the maintenance of the individual's right of self-determination, the matter would quickly resolve itself. But it is not. This is a question within the duty of care concept in negligence ... Negligence is not concerned with injury to dignity, but to the body or property. In order to estimate whether a contingency in the treatment was of sufficient significance to give rise to a duty of care to discuss it in order to avoid the forseeable risk of likely injury. The philosophical consideration could not be allowed to submerge every other.[79]

If the source of the action is indeed not solely the protection of integrity, then inevitably the patient, whose case consists of an allegation that his or her integrity was invaded, will have little hope of success. In any event, it is vital that there is a causal relationship between the wrong complained of and the subsequent harm.[80] In a situation where the patient's claim is satisfied by demonstrating that risks were not disclosed (not that they actually occurred), the source of the harm complained of is relatively straightforward - essentially a matter of fact. However, policy considerations can and do influence decisions, and courts have continued to balk at the provision of redress, and the imputation of negligence, where no measurable harm has actually arisen. The patient will, in these circumstances, find the negligence action considerably less than sympathetic to their claims. As was said in the case of Dessi[81] in 1980:

> Support for the subjective theory [of consent] derives from the broad principle underlying informed consent that a man is the master of his own body and may deal with it in whatever way he wishes, however irrational.[82]

In this case, as in Canterbury v. Spence,[83] this approach was, however, not ultimately held to be practical. Not only was there concern about the perceived likelihood of patients not telling precisely the truth, or at least being influenced by hindsight, but also the law's own need to have consistently applicable tests against which behaviour can be measured, means that a subjective test sits ill with negligence analysis.

Whilst some courts have been unprepared to give credibility to the professional test, it was imperative that a test was available for use. This test, developed in Canterbury v. Spence,[84] has come to be called the 'prudent patient' test - an objective test. However theoretically problematic it may seem to be to reconcile patient autonomy with anything other than a subjective test, such reconciliation was felt to be necessary, both to protect the general beneficence of medicine and the medical act, and to satisfy the rules of the law itself. Thus, the court made a brave attempt to marry two apparently conflicting aims. The formula was put thus:

> True consent to what happens to oneself is the informed exercise of a choice and that entails and opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent choice. From these almost axiomatic considerations springs the need, and in turn the requirement, of a reasonable divulgence by physician to patient to make such a decision possible.[85]

The crucial feature of this last passage from the judgement of the court is the insertion of the words 'reasonable' before 'divulgence' and 'intelligent' before 'choice'. 'Intelligent' choices may take a number of forms, and are open to considerable variations of interpretation. If 'intelligent' choices are measured at the personal level then they may be defined as 'intelligent' or rational even where the doctor or the judge might have decided in a different way. Equally, what is 'reasonable' disclosure will depend on the premise from which analysis begins. To the patient, 'reasonable' disclosure might mean full disclosure, whereas to the doctor 'reasonable' might merely mean disclosure only of information which gives the patient a broad notion of the possible risks, or some of them, but which equally does not deter the patient from accepting therapy. Provision of further information, following this argument, might seem to be folly - merely serving to increase the possibility that the patient will make an unintelligent or medically irrational choice.

That the court was aware of these possibilities is not in doubt, and if it was to maintain the appropriateness of these qualifications, and of the use of negligence analysis, then some definition of what was meant by these ambivalent words was necessary. It was in undertaking this exercise that the movement away from strict adherence to patient autonomy was most observable. As the court in Dessi put it:

> To inject a reasonable man standard into this [subjective] determination arguably undermines the patient's right to make his own decision. While this is a theoretically appealing rationale it ignores the practical problem with reliability of proof.[86]

In reality, this statement recognises the very problems which the Canterbury test sought to overcome. Dissatisfaction with merely acting on the word of the patient, and the corresponding fear of an unacceptable increase in litigation and expansion of liability, were thought to vindicate both the use of the negligence action and the setting of objective tests.

On the one hand, of course, this approach may serve to protect the patient by offering a standard which is separable - at least in theory - from the professional test. That is, it is a standard set by law. On the other hand, however, it generates the need for rationalised assessment of what the reasonable patient would have wanted in the way of disclosure. Even if this standard is set by law, it will almost inevitably be distanced to some extent from the views of the individual patient. Indeed, it is interesting to note that Mr. Justice Woodhouse himself, whose judgement in Smith [87] reinforced the professional test, and suggested that the negligence action was appropriate, became, several years later, one of the major critics of the negligence action, noting amongst other things, its incapacity to make decisions in the instant case, and its need to rationalise decision-making to the extent that neither is the individual satisfied nor is there truly an assessment of the behaviour of the individual defender.[88]

The court in Canterbury,[89] therefore, sought to offer a formulation which both satified the requirements of the negligence action itself, and represented a way of avoiding the over-expansion of liability which could result from a legal requirement to make full disclosure to patients. This is the 'prudent patient' test, formulated in this way:

> ...the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked. And to safeguard the patient's interest in achieving his own determination on treatment, the law must itself set the standard of adequate disclosure.[90]

However, this formulation evidently fails to answer the question as to how, without actually making the disclosure, it can be known whether or not any given piece of information would have a potential effect on the patient's decision. Who decides this? It is here that the move from the rhetoric of rights to the hard practicalities of 'realism' can be seen. Were commitment to patient autonomy truly regarded as the fundamental interest for protection, then - whatever the problems of proof - full disclosure would inevitably be required. The fact that patients might argue with hindsight in the subsequent court hearing, in essence poses no more difficulty than the assessment of witness credibility and conflicts of interest which are so often required of courts and juries.[91]

Inevitably, however, within negligence analysis, when the patient has identified the particular risk of which they were not informed, and which they claim would have affected their decision, the question of reasonableness must be addressed. This, of course, is only true in actions where the mere fact of non-disclosure is not the crucial factor. Absolute commitment to the rights of the patient would obviate the need to decide whether or not the patient was reasonable in claiming that he or she would have refused therapy had a particular risk or cluster of risks been disclosed. The issue would then become one of fact and evidence of non-disclosure would be sufficient to establish liability. Moreoever, reasonableness also features in the assessment of whether or not the risk <u>should</u> have been disclosed.

The major breakthrough, however, in the <u>Canterbury</u> judgement, relates to the court's insistence that the decision as to reasonableness is separable from professional (medical) assessment. As the court said:

> The disclosure doctrine, like others marking lines between permissable and inpermissable behaviour in medical practice is in essence a requirement of conduct prudent under the circumstances. Whenever non-disclosure of particular risk information is open to debate by reasonable minded men, the issue is for the finder of the facts.[92]

By this statement the court made it clear that, although the question did not hinge on whether or not disclosure had been made, the assessment of whether or not disclosure was appropriate in the circumstances was one which was properly made by the court. In other words, evidence that the doctor acted in good faith, and was not acting outside the bounds of his professionalism, could be, but would not necessarily be, sufficient for him or her to avoid liability.

However, by admitting the possibility that there may be circumstances in which non-disclosure is both prudent and justifiable, the court opened the door to the professional test. Thus, it was unprepared to import a subjective test, preferring an objective one, which, whilst admittedly much more commonly used in judicial decision-making, and fitting in much more easily with the format of the negligence action, nonetheless diminishes the right of the individual patient. The court regarded it as preferable that, although '..... the very purpose of the disclosure rule is to protect the patient against consequences which, if known, he would have avoided by foregoing the treatment ...',[93] the actual quality of disclosure should be tested on an objective standard.

Thus, the decision as to whether or not the patient <u>would</u> have avoided the therapy is undertaken by an objective analysis of what the reasonable or prudent patient would have regarded as significant, incorporating assessment of witness (i.e. patient) credibility. Whilst effectively saying that the patient's evidence as to whether or not he or she would have regarded the risk as significant could not necessarily be trusted, the court was nonetheless prepared to give considerable credibility to its own view of what would be significant, even although it is inevitably distanced from the views and circumstances of the particular patient. Although this may overtly diminish the input of the medical profession, it merely substitutes a further professional test - albeit the impressions of the judges rather than the doctors. As the court said:

> Better it is we believe to resolve the causality issue on an objective basis: in terms of what a prudent person in the patient's position would have decided if suitably informed of all perils bearing significance.[94]

The court effectively, therefore, enunciated a two-fold doctrine. Although generally assumed under the one heading - that of the 'prudent patient' test - in effect it includes two vital elements. In the first place, the question of which risks should be disclosed, is tailored to what resembles a variation on the reasonable doctor standard - a standard which the court actually sought to defeat. That is, the court approved the proposition that disclosure should be of material risk, not of every risk.[95] The decision as to what is a material risk is to be made in accordance with the definition given by Waltz and Scheuneman[96] of which the court expressly approved. Thus, a risk is material when:

> ....a reasonable person, in what the physician knows or should know to be the patient's position, would likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy.[97]

Materiality of risk is therefore is dependent on medical knowledge - even medical speculation. The actual wishes of the patient are subsumed in a variation of 'doctor knows best'. The standard of disclosure under the 'prudent patient' test is, therefore, not so dramatically different from that demanded by the professional standard, since in both cases medical judgement as to what needs to, or should, be disclosed is given legal sanction.

Moreover, in expressly accepting the concept of therapeutic privilege, and thus permitting the doctor to decide that risks should not be disclosed because the doctor regards them as risks which would distress the patient or which might deter the patient from therapy, the doctor is in real terms given considerable discretion. Ultimately, the position is tautologous. If the patient is to be given the benefit of risk disclosure because he or she has a right to decide whether or not to accept therapy, it is strange indeed that the doctor may equally not disclose risks because they may put the patient off the therapy. The doctor may be shielded therefore by invoking therapeutic privilege so long as there was nothing else in his or her behaviour which was unreasonable or negligent. This, despite the fact that the court did attempt to distinguish the purely medical aspect of the doctor-patient relationship from its other characteristics by noting that '[i]t is evident that many of the issues typically involved in non-disclosure cases do not reside peculiarly within the medical domain.'[98]

However, even under the 'prudent patient' test the reasonableness of the doctor's non-disclosure plays a significant part in estimating whether or not it is valid, and in this aspect also there is similarity to the 'prudent doctor' test. Just as the latter distances the need for disclosure from the instant patient, so too does the former. Not only does the patient have no immediate rights, therefore, but the assessment of what is a prudent patient will involve assessment of whether or not the therapy, in the eyes of the courts - and given the doctor's claims about the reasonableness of non-disclosure and the anticipated benefits of therapy - <u>should</u> have gone ahead.

To some extent, therefore, the 'prudent' patient will be someone who makes a medically (or legally) rational decision, and the group most likely to provide at least persuasive evidence in this assessment will, of course, be doctors themselves. It is arguable, therefore, that the distinction between the 'prudent doctor' test and the 'prudent patient' test may not be so substantial as was first thought. In any event, evidently neither test was prepared to countenance full disclosure, whatever its theoretical soundness. In the face of perceived difficulties of proof, and the undoubted value assumed in therapy, the patient becomes less of an individual whose own emotional and financial considerations are crucial to the information which they need, and more someone whose views, however strong, are susceptible to external 'objective' decision-making.

## Conclusions

In summary, therefore, the American courts have remained relatively committed to a medicalised assessment of the limitations of reasonable risk disclosure. This, despite the fact that the court in Canterbury acknowledged the difficulties of using professional tests. As Robertson points out:

> Two reasons in addition to the patient's right to self-determination, were given by the court to justify this departure from the established view that the meaning of "reasonable disclosure" was a matter for the medical profession to determine. First, it was thought that a standard of disclosure based on the custom of the medical profession could be a facade for non-disclosure. Secondly, the court felt that the question of what risks a person would regard as material was an issue which could be determined without special knowledge of medical science.[99]

However, even in their reformulation of the appropriate test, medical evidence carries weight. In any event the most significant exception to rules demanding disclosure

- that of therapeutic privilege[100] - re-emphasises medical assessment of behaviour as a highly significant criterion in decision-making. This permits of a reincorporation of the kinds of paternalistic explanations for non-disclosure discussed above, and can serve to validate the importance of professional rather than personal choice.

In the United States, therefore, it seems that the shift to the negligence action did not - at a theoretical level at least - necessarily involve a complete disregard for the value to be attached to patient's rights, and in particular to the right of self-determination. However, a standard against which the doctor's duties could routinely be measured was necessary. Indeed, quite apart from the requirements of the negligence action itself, it could be argued that, were an objective approach not taken, then the doctor would be placed in an unusual position by the law - a position which would certainly render him or her more vulnerable than the ordinary citizen to whom the 'reasonable man' standard is applied. In other words, the use of an objective test could be seen as essential if doctors are not to be penalised merely because they are physicians.

It could be argued, however, that medicine itself is more intrusive than other disciplines, and its implications (whether successful or not) are such that what the law must protect is so fundamental a value in itself, that differential treatment can be justified -

much along the lines of the rule that the higher the risk of the enterprise, the higher the standard of care which is to be expected.[101] When this argument is coupled with the value generally ascribed to the capacity to exercise self-determination, then it could be concluded that the importation of special rules is merited on these grounds alone, even if this does involve a deviation from the legal norm. However, whether or not this last is accepted, the negligence action seems unsuited to calculations which would result in increased protection of fundamental rights.

It has been seen that American courts have directed not inconsiderable attention to the nature of the test to be applied. The development of the 'prudent doctor' test and the 'prudent patient' test show a commitment to the resolution of what is genuinely an immensely complex area of debate. However, both also reflect inherent difficulties where what is under consideration is not the factual question of whether or not information was disclosed, but rather an 'objective' assessment of the correlation between rights and duties. The 'prudent doctor' test, in particular, which still obtains in the majority of states, highlights just such a difficulty. Emphasis on standard or reasonable medical practice serves the medical profession well, but scarcely satisfies a real concern for patient's rights. It is, in effect, to give priority to the duty, rather than the right from which the duty is derivative, and inevitably it permits the extensive and primary use of medical evidence. This is so, even although courts maintain their right to decide that standard practice is not appropriate or satisfactory.[102]

Dependence on reasonableness also introduces further problems which the patient would have to overcome. Even if it is the court, and not the medical profession, which decides on reasonableness, expert evidence will be required. As with most professions, and this was noted in Canterbury v. Spence,[103] it is often very difficult to obtain expert testimony which would suggest that a professional colleague has been negligent, and the evidence of an expert - if one can be found - is likely to be given with the possible implications of a finding of negligence very much in mind. It would be disingenuous to pretend that such evidence will not weigh heavily with a court.

The 'objective' test also maximises the distance between the rights of the individual patient and the amount of information to which he or she is entitled, requiring a rationalised view of the instant doctor's behaviour. The description of a given patient's rights, and indeed of all patients' rights, is inappropriately based on the description of what is professionally acceptable - even professionally optimal - behaviour.

Moreover, as already has been noted, practices which develop may not in themselves be negligent. Courts will be loath, therefore, to regard them as professionally or legally culpable, because ultimately they serve the interests of medical care and do not prejudice reasonable medical practice. However, from the patient's point of view, they may be unacceptable, invasive and personally unsatisfactory. The intervention of medicine, therefore, may cause the patient harm, without being bad practice in strictly medical terms. The assertion that the provision of information is only tenuously linked to the technical behaviour of the doctor is thus reinforced.

At first sight, the use of the 'prudent patient' test seems to offer a greater protection to the patient. However, as has been shown, in effect - and even discounting the exceptions to the rule - it too equates, in part, to a type of professional standard. Implicit in it are fundamental value judgements, which start from the assumption that not all information need be disclosed. Moreover, whereas the reasonableness test is generally used in the negligence action to assess the behaviour of the person defending the action, it is here also used in respect of the person claiming to have been harmed. In other situations this is common only where there is a suggestion of contributory negligence. This can scarcely be an issue, however, in cases concerning non-disclosure of risks. The court, therefore, must speculate on two matters fundamental to the case.

On the one hand, they must guess what the reasonable or prudent patient is, and what information would have affected his or her choice. In fact - even with a highly credible patient witness - the court may be prepared to decide that the information was not material to the decision, or rather that the information should not have been regarded as vital. On the other hand, and again because the negligence action focuses on doctors' duties, they must also decide whether non-disclosure demonstrates actual negligence - that is breach of the doctor's duty of care to that particular patient, or to patients in general. Thus, the question in issue becomes divorced from the patient's immediate rights.

Neither of the above assessments is solely a question of fact. Rather they are value-judgements which permit of the incorporation of numerous extra-legal factors into the equation - factors which often seem to value therapy over non-therapy, and an otherwise competent and highly respected professional over an aggrieved 'consumer'. When the exceptions to the position are admitted, and in particular that of 'therapeutic privilege', it is even more evident that professional evidence and standards play a highly significant role in the ultimate determination of the case.

It can be concluded therefore, that the 'prudent patient' test is some improvement on the 'prudent doctor' test in the protection of patients' rights, but it by no means represents the radical alternative which it is often represented as doing. Talk of human rights in this area, therefore, can be said on occasion merely to have disguised the continued use of policy considerations, rather than offering real protection to the patient. It may be the case, as Robertson suggests, that the acceptance of the concept of 'informed consent' by American courts represents a desire to expand the liability of the medical profession,[104] but it is submitted that it has scarcely achieved this, except in cases where the failure to disclose is so gross as to have, in any event, satisfied many of the criteria which could stimulate assault analysis.

NOTES

1. see chapter 3, supra
2. see chapter 4, supra
3. Lawson, F.H. and Markesinis, B.S., Tortious Liability for Unintentional Harm in the Common Law and the Civil Law, (Vol. 1), Cambridge, Cambridge University Press, 1982.
4. at pp. 44-45
5. Skegg, P.D.G., Law, Ethics and Medicine, Oxford, Oxford University Press, 1984 at p. 83.
6. c.f. Paris v. Stepney Borough Council [1951] A.C. 367; Lloyd's Bank v. E.B. Savoury & Co. [1933] A.C. 233; General Cleaning Contractors v. Christmas [1952] 2 All E.R. 1116; Barkway v.

South Wales Transport [1950] 1 All E.R. 402; see also the comments of Lord Clyde in Hunter v. Hanley 1955 S.C. 200; Norrie, K. McK., 'Common Practice and the Standard of Care in Medical Negligence', (1985) Juridical Review 145; for further discussion of the general points of law, see Walker, D.M., The Law of Delict in Scotland, (2nd Ed., revised), Edinburgh, W. Green & Son Ltd., 1981, pp. 205-6; Rogers, W.V.H., Winfield and Jolowicz on Tort, (12th. Ed.), London, Sweet & Maxwell, 1984, pp. 102-104.

7. Hunter v. Hanley, supra cit.

8. supra cit.

9. The test was expressed in this case thus: 'To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all, it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.', per Lord Clyde, at p. 206; see also, more recently, the judgement of Peter Pain, J., in Clark v. Maclennan [1983] 1 All E.R. 416, at pp. 424-5: '...a doctor owes a duty

to his patient to observe the precautions which are normal in the course of the treatment that he gives. But, where there are two schools of thought as to the right course to be followed, he may not be charged with negligence simply because he chooses one course rather than the other. Where however there is but one orthodox course of treatment and he chooses to depart from that, his position is different. It is not enough for him to say as to his decision simply that it was based on his clinical judgment. One has to enquire whether he took all proper factors into account which he knew or should have known, and whether his departure from the orthodox course can be justified on the basis of these factors.'

10. but see the <u>caveat</u> introduced in <u>Sidaway</u> v. <u>Bethlem Hospital Board of Governors</u> [1984] 1 All E.R. 1018 by Sir John Donaldson M.R. who suggested that a refinement of the test outlined in <u>Bolam</u> v. <u>Friern</u> H.M.C. [1957] 2 All E.R. 118, was appropriate. At p. 1028, he said that the law 'could not stand by if the profession, by an excess of paternalism, denied their patients a real choice.' He further indicated, at p. 1028 that a practice must be '...<u>rightly</u> accepted as proper by a body of skilled and experienced medical men.'; see also, Norrie, K. McK., 'Standards of Disclosure' 1984 <u>S.L.T.</u> 237.

11. Hunter v. Hanley, supra cit.; Clark v. Maclennan, supra cit.

12. see chapter 1, supra.

13. Walker, op.cit., at pp.346-347 says of volenti non fit injuria: 'For the plea to apply it must be shown that the pursuer was both sciens and volens, that he fully appreciated the dangerous character of the situation brought about and also exhibited a real consent to his own assumption of the risk in question without right to compensation from the defender.'; Walker continues at p. 347: 'If the plea is to succees it must be shown not that the pursuer consented to take the risk of some harm befalling him, but that he consented to take the risk of the particular kind of harm which in fact befell him.'; this should be considered also in the light of the judgement in Chatterton v. Gerson & Anor. [1981] 1 All E.R.257; for further discussion of this case, see chapter 6, infra; see also the comments of Scott, L.J. in Bowater v. Rowley Regis B.C. [1944] 1 K.B. 476, at p. 479.

14. see chapter 8, infra.

15. Gordon, G.H., The Criminal Law of Scotland, (2nd. Ed.) Edinburgh, W. Green & Son Ltd., 1978 at p. 828: 'In the case of surgical operations consent is a defence even where the injuries caused are likely to cause danger to life. This is probably because the injuries are inflicted in such cases

not for their own sake or in order to cause pain or gratify an intention to harm, but for the benefit of the patient.'

16. H.M.A. v. Rutherford 1947 J.C. 1; Rex v. Donovan [1934] 2 K.B. 498; see also Gordon, op.cit, at p. 765; Williams, G., Textbook of Criminal Law, London, Stevens & Sons., (2nd Ed.) 1983. But see R. V. Arthur 'The Times' 6 Nov. 1981

17. In Bravery v. Bravery [1954] 3 All E.R. 59, at p. 68; 'Take a case where a sterilisation operation is done so as to enable a man to have the pleasure of sexual intercourse without shouldering the responsibilitiies attaching to it. The operation then is plainly injurious to the public interest. It is degrading to the man himself. It is injurious to his wife and any woman whom he may marry, to say nothing of the way it opens to licentiousness; and, unlike contraceptives, it allows no room for a change of mind on either side. It is illegal, even though the man consents to it...' (emphasis added)

18. c.f. Gonzales, B., 'Voluntary Sterilization: Counselling as a Prerequisite to Informed Consent', Proceedings of the 5th. World Congress on Medical Law (1979).

19. see, Walker, op.cit., at pp. 346-347; Winfield and Jolowicz on Tort, op.cit., p. 700 et seq.; Street on Torts (7th. Ed.), London, Butterworths,

1983, pp. 153-155.

20. supra cit.

21. ibid., at p. 479.

22. Robertson, G., 'Informed Consent to Medical Treatment' 97 Law Quarterly Review 102, at p. 103.

23. Hollander, R.D., 'Changes in the Concept of Informed Consent in Medical Encounters' 59 J. Med. Education 783 (1984) at p. 784.

24. See Crawford v. Board of Governors of Charing Cross Hospital 'The Times' 8 December 1953 (C.A.) per Lord Denning; '...it would be quite wrong to suggest that a medical man is negligent because he does not at once put into operation the suggestions which some contributor or other might make in a medical journal. The time may come in a particular case when a recommendation may be so well proved and so well known and so well accepted that it should be adopted, but that was not so in this case.'

25. per Cardozo, J., in Schloendorff v. Society of New York Hospitals (1914) 105 N.E. 92, at p. 93.

26. Hollander, loc.cit., at p. 784.

27. supra cit., at p. 217.

28. loc.cit., at p. 223

29. 'The Times' 2 July 1954.

30. see chapter 2, supra.

31. c.f. Buchanan, A., 'Medical Paternalism' 7 Philosophy and Public Affairs 49 (1979).

32. for discussion, see Buchanan, loc.cit.; McLean, S.A.M. and McKay, A.J., 'Consent in Medical Practice', in McLean, S.A.M., (ed) Legal Issues in Medicine, Aldershot, Gower, 1981; Shultz, loc.cit.; Hollander, loc.cit.

33. see chapter 2, supra.

34. 464 F 2d 772 (1972)

35. at p. 780.

36. at p.778

37. Chatterton v. Gerson, supra cit., at p. 266: '...there is no obligation on the doctor to canvass with the patient anything other than the inherent implications of the particular operation he intends to carry out. He is certainly under no obligation to say that if he operates incompetently he will do damage.'

38. loc.cit.

39. ibid., at pp. 111-112.

40. loc.cit., at p. 112.

41. loc.cit.

42. see chapter 2, supra; Buchanan, loc.cit.

43. c.f. Stanway, A., Alternative Medicine, Harmondsworth, Penguin, 1982, particularly chapter 1.

44. c.f., Stanway, op.cit., at pp. 16-17 where he claims that only approximately 20% of patients consulting doctors will actually benefit from orthodox medicine, at p. 17: 'The other 80 per

cent...simply don't need Western medicine per se. Many of them would fare just as well if they didn't live in the sophisticated western world and from a sociological standpoint many would fare better in a society in which family ties were stronger and a sense of close community help more meaningful than it is in the West today.'; he continues, at p. 18: 'We have to face up to the fact that modern medicine as we know it has done little to cure or prevent disease when compared with the advantages conferred upon society by good sanitation, improved housing, smaller families and other social improvements.'

45. supra cit.

46. per McNair, J., at p. 124.

47. loc.cit.

48. ibid., at p. 222

49. Giesen, D., Medical Malpractice Law, Gieseking-Verlag Bielefeld, 1981.

50. op.cit., at p. 163.

51. for further discussion, see chapter 8, infra.

52. op.cit., at p. 85.

53. e.g. Canterbury v. Spence, supra cit., at p. 784.

54. Harris, P., An Introduction to Law, (2nd Ed.) London, Weidenfeld & Nicolson, 1984.

55. at p. 379.

56. for further discussion, see chapter 9, infra; see also, Lord Scarman in McLoughlin v. O'Brian [1982]

2 All E.R. 298, at p. 310 'By concentrating on principle the judges can keep the common law alive, flexible and consistent, and can keep the legal system clear of policy problems which neither they nor the forensic process which it is their duty to operate, are equipped to resolve.'

57. for discussion, see Robertson, loc.cit.; Skegg, P.D.G., 'Informed Consent to Medical Procedures' (1975) 15 Med.Sci.Law 124.; Brazier, M., 'Informed Consent to Surgery' (1979) 19 Med. Sci.Law 49; Strong, C.,'Informed Consent: Theory and Policy' (1979) 5 J.Med. Ethics 196; Meisel, M., 'The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent' (1977) 56 Neb. L. Rev. 51; Kussman, R.S., 'Informed Consent: New Rulings, New Concepts, New Terms', Legal Aspects Med. Practice 4 (1981); Picard, E., 'Consent to Medical Treatment in Canada' 19 Osgoode Hall Law Journal, 140, (1981).

58. supra cit.

59. loc.cit., at p. 220

60. 123 Va. 113 (1918).

61. at pp. 133-134.

62. 154 Cal App. 2d 560, 317 P. 2d 170 (1957).

63. ibid., at p. 578; 317 P. 2d at pp. 180-181.

64. Montrose, J.L., 'Is Negligence an Ethical or Sociological Concept?' (1958) 21 M.L.R. 259, at p.

263.

65. 186 Kan. 393, 350 P. 2d 1093 (1960); at p. 410 (350 P. 2d at p. 1106) the court said that the doctor had a duty to make a 'reasonable disclosure...of the nature and probable consequences of the suggested or recommended...treatment, and...a reasonable disclosure of the dangers within his knowledge which are incident to, or possible in, the treatment which he proposes to administer.'

66. see chapters 2 and 4, _supra_

67. c.f. Mason and McCall Smith, _op.cit._, n. 11, p. 154 'Approximately three-quarters of the United States adhere to a professional standard.'

68. _supra cit._; see also, Seidelson, 'Medical Malpractice: Informed Consent in "Full Disclosure" Jurisdictions' (1976) _14_ _Duq. L. Rev._ 309.

69. at p.779

70. at p.781

71. _id._

72. at p. 784.

73. see note 67 _supra_; see also _Smith_ v. _Auckland Hospital Board_ [1964] N.Z.L.R. 241, [1965] N.Z.L.R. 191 (New Zealand); _Male_ v. _Hopmans et al._ (1965) 54 D.L.R. (2d) 592; _Kenny_ v. _Lockwood_ [1932] 1 D.L.R. 507; _Reibl_ v. _Hughes_ (1980) 114 D.L.R. (3d) 1 (Canada); _Battersby_ v. _Tottman and_

State of South Australia (1985) 37 SASR 524 (Australia); but see also, Crichton v. Hastings et al. (1972) 29 D.L.R. (3d) 692; Hopp v. Lepp (1979) 98 D.L.R. (3d) 464

74. supra cit.

75. id. 'The context in which the duty of risk-disclosure arises is invariably the occasion for the decision as to whether a particular treatment procedure is to be undertaken. To the physician, whose training enables a self-satisfying evaluation, the answer may seem clear, but it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie.'

76. c.f. Dessi v. U.S.A. 489 F. Supp. 722 (1980) 'Support for the subjective theory [of consent] derives from the broad principle underlying informed consent that a man is the master of his own body and may do with it whatever he wishes, however irrational. To inject a reasonable man standard into this determination arguably undermines the patient's right to make his own decision. While this is a theoretically appealing rationale, it ignores the practical problem with reliability of proof.' (emphasis added)

77. for discussion, see Walker, op.cit.; Street on Torts, op.cit.; Winfield and Jolowicz on Tort, op.cit.; Atiyah, P.S., Accidents, Compensation

and the Law, (3rd Ed.) London, Weidenfeld & Nicolson, reprinted 1984, ch. 4.

78. supra cit.

79. at p. 247

80. e.g. in Chrichton v. Hastings et al. 29 D.L.R. (3d) 692 (1972), Brooke, J.A. (dissenting) said, at p. 704: 'Mere failure to warn is not actionable negligence. It must be established that such failure caused or contributed to the respondent's injury and damage.'

81. supra cit.

82. supra cit., note 76.

83. supra cit.

84. supra cit.

85. at p.777

86. supra cit., note 76

87. supra cit.

88. Report of the Royal Commission of Inquiry on Compensation for Personal Injuries in New Zealand (Government Printer, New Zealand, 1967); for further discussion, see chapter 7, infra.

89. supra cit.

90. at p.786

91. see e.g. Thake v. Maurice [1986] 1 All E.R. 497, per Nourse, J., at p. 511: 'The function of the court in ascertaining objectively the meaning of words used by contracting parties is one of everyday occurrence. But it is often extremely

difficult to discharge it where the subjective understandings and intentions of the parties are clear and opposed.'; on witness hindsight, see Carmarthenshire C.C. v. Lewis [1955] A.C. 549.

92. at p.787

93. at p.790

94. at p.791

95. at pp. 786-7: 'Thus, the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked.'

96. 'Informed Consent to Therapy' 64 N.W.U.L. Rev. 628 (1969)

97. *ibid.*, at p. 780

98. at p.792

99. *loc.cit.*, at p. 106.

100. thus, an exception was allowed 'when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view.', at pp.788-9. This exception was also supported by Lord Scarman in *Sidaway*, *supra cit.*

101. *Muir* v. *Glasgow Corporation* 1943 S.C. (H.L.) 3, per Lord Macmillan at p. 10: 'Those who engage in operations inherently dangerous must take precautions which are not required of persons engaged in the ordinary routine of daily life.'; see also, *Paris* v. *Stepney Borough Council* [1951]

A.C. 367; Lloyd's Bank v. Railway Exec. [1952] 1 All E.R. 1248; Gilmour v. Simpson 1958 S.C. 477. For further discussion, see Walker, op.cit. at pp.202-205; Winfield and Jolowicz on Tort, op.cit., at pp.69 et seq.

102. c.f. Sir John Donaldson in Sidaway, supra cit., at p. 1028 that the law would only support a practice '...rightly accepted as proper by a body of skilled and experienced medical man.'; but see also the importance given to medical assessment in Kenny v. Lockwood, supra cit., per Hodgins, J.A. at p. 524; 'While it is of course the duty of the Court in this case...to decide on the extent and import of the duty arising out of the relationship of surgeon and patient as reflected in the evidence given I think the greatest attention should in a case of this kind be paid to the views of those on whom great responsibility is thrown in every surgical case.'

103. supra cit.

104. loc.cit., at p. 109.

# INFORMATION DISCLOSURE, CONSENT TO MEDICAL TREATMENT AND THE LAW

by

SHEILA ANN MANSON McLEAN

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# CONSENT IN THE U K

## CHAPTER 6

British courts routinely show less verbal concern for questions of human rights, but this is not to say that they do not recognise them, nor that they do not regard them as significant. Merely, their language differs from that of their American counterparts. Thus, it is equally fundamental to British law and legal process that basic rights are protected, and that remedies are made available to redress legitimate grievances. The form of the available remedy will, as in the United States, play a part in determining the ease with which redress can be obtained. As has been noted, British courts have also moved from the assault based action to the negligence action in response to criteria similar to those which influenced the United States courts.[1] Moreover, the tests for negligence in the United Kingdom are in general equivalent to the tests used in the United States.[2]

It has been suggested above,[3] however, that there remains a distinction between the negligence action in general and the negligence action in medical cases. Where the alleged negligence is a failure in information disclosure there is reason to assume that any apparent differentiation will equally apply here. In other words, unless the issue of disclosure is regarded as a special and separate issue, the use of extra-legal criteria will be evident also in cases concerning the validity and quality of consent.

British courts have in fact, until recently apparently given little consideration to the question of what information must be disclosed before a medical consent is real and effective.[4] The negligence action has long been preferred and what is generally under consideration, therefore, is primarily whether or not the doctor acted in a professionally acceptable way. Robertson[5] suggests that there effectively was no doctrine specifically applying to the disclosure of information in British law until the 1970s, and the case of Chatterton v. Gerson.[6] This, of course, does not mean that such matters were not considered in the past, but rather that no special status had been accorded to the question of consent by British courts, even in those cases where it was central to the issue.

The leading cases which Robertson uses to substantiate this suggestion are the cases of Hatcher v. Black[7] and Bolam v. Friern Hospital Management Committee.[8] Both, according to Robertson, demonstrate that there was no comprehensive or comprehensible doctrine relating to 'informed' or real consent in medical cases.[9] Indeed, in neither case was there an enunciation of a special doctrine of consent - whatever its terminology - and in fact the emphasis on patient's rights which could be encapsulated in such a doctrine, and reinforced by judicial pronouncement, seems to be quite clearly lacking.

Whilst their American colleagues struggled to find an acceptable test to measure the extent of necessary disclosure and the situations in which it must, could, or should be made, British courts tended to remain comfortable with a relatively simplistic professional model. The two significant characteristics of the application of the negligence action in medical cases in the United Kingdom have been the almost overwhelming weight placed on medical judgement and the deference shown to orthodox medicine and its therapies. Thus, even the Royal Commission on Civil Liability and Compensation for Personal Injury (Pearson Commission),[10] when considering problems of disclosure suggested that, '[a] balance has to be maintained between the possible consequences of treatment and the possible outcome if treatment is not carried out.'[11] In other words, what is weighed in the scales of justice when it is alleged that insufficient information has been disclosed, will inevitably bear in mind the potential benefit of therapy, even where this conflicts with the perspective of the individual patient raising the complaint. This deference to the medical view has been identified by a number of writers and is by no means a trivial point. Klass,[12] for example, suggests that this attitude is one possible reason for the huge (and he considers excessive) prescription of drugs in the United Kingdom. Failure to challenge the practice of medical practitioners, even in the routine transaction has led, or may lead, to general societal unwillingness to challenge other aspects of medicine.

British courts, therefore, have seldom contemplated with any degree of seriousness a deviation from the professional test, which is generally used in medical cases as definitive, rather than merely persuasive. Thus, the professional standard sets the initial pace, and when combined with a desire to protect and advance the 'good' of orthodox medicine, provides a strong disincentive to admit the validity of challenges to medical behaviour. There was, in the United Kingdom, therefore, neither the desire, nor the apparent need, to consider the possible application of an equivalent to the 'prudent patient' test.

It was said above that the use of the term 'informed' to qualify 'consent' was in many ways problematic, and that for this reason it would not routinely be used in this discussion.[13] Indeed, it has been expressly stated in one English case that informed consent forms no part of the English law[14] - nor, one can reasonably assume, of Scottish law.[15] The difficulties inherent in the use of the concept of being 'informed' will be further discussed below, but for the moment it is necessary only to point out that although eschewing 'informed' consent, British courts do not deny the importance of a real or legal consent - merely they reject the terminology. As Robertson notes:

> It is firmly established in English law that, in the absence of exceptional circumstances, such as an emergency situation, a doctor must obtain the consent of his patient before undertaking treatment involving physical contact with his patient.[16]

This, however, does not mean merely an overt consent, but rather entails a more complex assessment of the nature and extent of the information disclosed or withheld in order to decide whether or not the patient was both *sciens* and *volens*.[17] The significance of this relates to the fact that the defence of *volenti non fit injuria*[18] will apply where risks are in fact consented to. The doctor who obtains a real consent both protects him or herself against allegations of illegality, and safeguards the moral nature of his or her intervention. As the court said in *Bowater* v. *Rowley Regis B.C.*[19]:

> In regard to the doctrine *volenti non fit injuria*, I would add one reflection of a general kind. That general maxim has to be applied with especially careful regard to the varying facts of human affairs and human nature in any particular case, just because it is concerned with the intangible factors of mind and will....A man cannot be said to be truly "willing" unless he is in a position to choose freely; and freedom of choice predicates...full knowledge of the circumstances upon which the exercise of choice is conditioned...[20]

However, as been noted, interpretation of what amounts to a real consent to therapy depends on the assessment of the quality, nature and extent of necessary information disclosure - ultimately, in cases of dispute, assessment by the law. Thus, the method by which challenges are made and the tests applied in decision making will play a crucial role in determining the amount of information disclosure which is legally necessary, and thereby will describe the extent to which the patient has rights to information, and by implication, the extent to which the patient can expect his or her right to self-determination in medicine to be upheld by the law.

The earlier cases such as Hatcher[21] and Bolam,[22] did not distinguish the provision of information from any other aspect of the doctor's duty of care to his or her patient. No consideration was given to the possibility that there was a difference between technical skills and non-technical skills, nor that the interests protected by rules about disclosure might be of more significance than the possibility, or even probability, of cure or relief of suffering. Thus, although both cases discussed the question of disclosure, they also gave considerable credence to the kinds of arguments so successfully challenged by Buchanan.[23] In Bolam,[24] for example, the judge suggested to the jury that where the doctor feels that the therapy in question is the only hope of cure or alleviation of symptoms, and fears that the patient may be put off the therapy if all the risks are made known, then they might not wish to criticise the doctor for failing to inform the patient of the risks - as indeed the jury did not. As this case plays a significant role in future decisions, it is worth considering it in more detail.

The patient in question was suffering from depression, and ultimately the doctor formed the view that the treatment most likely to offer a cure was electroconvulsive therapy. In administering this therapy there were two schools of thought. One advocated the use of muscle-relaxants to prevent fracture in the convulsions which are inherent in the treatment and the other did not. Doubtless there were sound scientific reasons underlying each school of thought. The doctor in the instant case subscribed to the view that muscle relaxants were not necessary, and there was no suggestion that he was negligent in holding this position. However, he equally did not warn the patient of the risks of fracture which he knew to be possible, although, in his view, not highly probable. In the event, the patient did sustain fractures, and sued on the basis that he was inadequately informed. In deciding that the doctor was not negligent in having failed to warn of a known risk, a number of interesting points emerged.

First, the fact that the patient was mentally disturbed, which might in other circumstances have indicated that he could not have legally consented whatever information was disclosed, was used instead as a reason, or a justification, for non-disclosure of information, thus minimising his already tenuous capacity to give a real consent. Moreover, the court at no stage challenged the validity of the assertion that electroconvulsive therapy is in fact therapeutically valuable. And, finally, the court made it clear that the fact that a doctor differs in practice from his colleagues does not render him negligent, unless the deviation is such that a reasonably competent doctor would not have made it - following the rule in Hunter v. Hanley.[25] The obligation to make disclosure was not denied, but the court chose to see it as defined not in terms of patients' rights, but rather - and very specifically - in terms of doctors' duties. The obligation of the doctor, therefore, is merely to act in a reasonably skilful manner in the exercise of his or her profession. Duties in respect of the provision of information and the exercise of technical skills, are not therefore distinguished in any way, and '... the issue of whether this duty encompasses the giving of information relating to risks inherent in the treatment is a question, not of law, but of reasonable medical judgement.'[26]

Again, therefore, the central element in assessing the quality of medical behaviour was deemed to be the evidence as to whether or not other doctors, as representatives of a responsible body of medical opinion, would or would not have made disclosure. There are two vital points here. First, the court, of course, can reserve the right to decide that any professional practice is negligent, since professional practice is founded on criteria, and rooted in traditions, which are not necessarily those of the law. Negligence is a legal concept legally defined, and serves a purpose far beyond that which is sought by the development of professional practices and techniques.[27] The law can, and in some situations does, fly in the face of professional practice in the interests of justice.[28] In Bolam,[29] however, the court seemed content to bind its own hands and feet to the professional standard, and to shut off the possibility that the law might set different standards. In many ways, this attitude is reminiscent of that taken in R. v. Arthur,[30] where the problems of accepting such attitudes are perhaps more overt.

In the latter case, there were clear and undeniable problems - morally at least - in merely accepting current medical practice as the best standard to be set. Here, the medical practice which was supported was the deliberate non-treatment of handicapped babies, where prognosis was poor and the parents did not wish the child to survive. Whatever side of the moral debate one might wish to choose, it is surely surprising to hear a judge directing the jury that they should think long and hard before deciding that standard medical practice was criminal. It is not clear why this should be the case, when the intention and the effect of the practice was to kill (normally illegal), and this was not disputed.[31] Moreover, standard practice is a concept scarcely relevant to the criminal law, and yet it featured significantly in the trial and subsequent acquittal.

This case could be said to illustrate the reluctance of courts to set their own standards in medical cases, even in the face of what would otherwise be a criminal offence. Merely as an hypothesis, then, how much less likely are they to insist that standard practice is negligent, where the situation is, at least at first sight, much less potentially dangerous and much more closely tied to normal medical practice, that is, to decisions about therapy, rather than to killing (or letting die)? Indeed, in Bolam,[32] there was no serious suggestion that medical evidence as to practice should be anything other than determinative of the issue. Nor was the possibility of deciding between the merits of individual practices seriously countenanced by the court.[33] The so-called Bolam Test, which emerged from this case, indicated that where a doctor acts in accordance with a school of thought accepted as reasonable by a responsible body of medical opinion, then he or she will not be negligent. The effect of this is that the assessment of what amounts to evidence satisfying the legal concept of negligence is determined substantially by the medical profession, and its boundaries are essentially set by medical practice. This is problematic enough in allegations of technical negligence,[34] but how much more problematic when it is not the doctor's skills as a practitioner which are under scrutiny, but his or her response to, and respect for, his patients' rights?

In setting this standard for decision-making, Bolam was the landmark decision in British jurisprudence for some considerable time, although its status could have been challenged by a superior court. However, the use of the professional test clearly provided the British courts with a manageable instrument, which fitted in well with the nature of the negligence action and with their own preconceptions about the impact of negligence litigation on the practice of orthodox medicine. Scant attention was paid to the claims of patients to have rights in this interaction. Not, that is, rights to a cure, but certainly rights to be respected as human beings and to make choices about their own therapy based on a sufficiency of information. Moreover, the Bolam test has found extensive support in subsequent cases, making it the cornerstone of decision-making in cases of this sort.[35]

In Thake v. Maurice,[36] for example, the court held out the possibility that the surgeon in question could have provided himself with a legal excuse for his somewhat vague explanation had he claimed that it was not common practice to give any more clear an explanation. As Kerr, L.J. said:

> It would have been open to the defendant to qualify the answers which he gave either in cross-examination or re-examination, by

> saying that he did not believe that it was the general practice to give any such warning or that other surgeons might consider this to be necessary. He was given the opportunity of doing so in a later part of his cross-examination when it was suggested to him that he might not have given the warning because this might have caused worry or concern to the plaintiffs, but he did not accept this. Accordingly, ... in the present case there was nothing to be placed in the balance against the need for the warning which the defendant himself recognised in his evidence.[37]

In sum, therefore, the British courts have made no real pretence at setting anything other than a professional test for disclosure. The emphasis is on the doctor's duty and not on the patient's rights, thus making the evidence of fellow professionals of similar significance in disclosure cases as it is in cases involving the application of technical skills. In fact, only Sir John Donaldson in the Court of Appeal judgement in Sidaway,[38] and Lord Scarman[39] in the House of Lords made any real attempt to override the dominance of professional evidence. The courts, however, have nonetheless laid down the rough tests to which they hold doctors accountable,[40] and it is therefore possible to argue that there remains the possibility of the courts not placing overriding emphasis on the evidence of the doctor and his or her fellow professionals, and that they can and will consider the question of whether or not a doctor's non-disclosure was negligent in the light of alternative criteria. If this were indeed the case, then the concern generated by the use of the professional test might at best be misplaced, and at worst exaggerated. What, therefore, do the courts have to say about disclosure, independently of the medical profession?

## The Duty to Disclose

As has already been noted, the duty to make disclosure to a patient is, in British law, apparently an aspect simply of the doctor's professional duty of care towards his or her patient. Nonetheless, this need not mean that the court have no say in its definition. Despite the translation of patients' rights into doctors' duties, which seems to be an unavoidable implication of the shift from assault to negligence, the courts could nonetheless play a substantial role in protecting patients' rights, even in an action which may apparently be inherently ill-suited to this. In other words, the law could, by setting sufficiently clear and unequivocal tests, still assess the question of disclosure with a relatively critical eye. Even where the professional test takes priority, this remains possible.

What then is the standard set by British courts? Accepting that neither Bolam[41] nor Hatcher[42] did any more than indicate that the courts would pay primary attention to evidence of other doctors and to the therapeutic imperative, the case of Chatterton v. Gerson[43] seems to have been the first to make a real attempt at defining what information should, in the abstract, be disclosed to the patient in order to make the consent of the patient both technically possible and legally meaningful. Chatterton[44] also made it clear that, save in cases of gross failure to disclose, the appropriate form of action lies in negligence. The court stated the doctor's duty of care thus,:

> In my judgement there is no obligation on the doctor to canvass with the patient anything other than the inherent implications of the particular operation that he intends to carry out. He is certainly under no obligation to say that if he operates incompetently he will do damage. The fundamental assumption is that he knows his job and that he will do it properly but he ought to warn of what may happen by misfortune however well the operation is performed, if there is a real risk of misfortune inherent in the procedure.[45]

This statement of what information need be disclosed poses a number of problems for the disaffected patient. On the one hand, the assessment of what is a 'real' risk could be made on the basis of a statistical calculation, a method already criticised as unsatisfactory.[46] Further, as Robertson notes:

> The adoption of this standard negligence formula in the present context can be seen to imply that the doctor's duty to disclose the "real risk" of the operation stems from his overall duty to exercise reasonable care in the treatment of his patient. The doctor is under a duty to take reasonable care to avoid exposing his patient to any foreseeable risk of injury, and, as the decided cases indicate, "foreseeable risk" is equated with "real risk". Thus, it would follow that the source of the duty to inform the patient of

> the "real" risk inherent in the proposed treatment is simply the overall duty of care arising from the doctor-patient relationship.[47]

Thus, even the apparent freedom of the court to decide what is 'real' risk, nonetheless requires an assessment which is intimately linked with what is reasonable medical practice in the circumstances, since the obligation to disclose is merely one aspect of the doctor's overall duty of care. Clearly this has implications for patients' rights. Indeed, if this is the test applied, and Chatterton has consistently been referred to with approval by subsequent courts,[48] the:

> ....disclosure of risks inherent in the proposed treatment will be seen as a product of the doctor's duty of care rather than as a product of the patient's right to self-determination. Thus, since the doctor's duty of care is defined in terms of acting as a reasonable doctor, there is a danger that in the future English courts will see the duty to disclose inherent risks as stemming from the fact that reasonable doctors disclose such risks (which may be subject to rebuttal by medical evidence) rather than from the fact that the patients' right to self-determination demands such disclosure.[49]

Although somewhat vague, therefore, it can be seen that the risks which British courts expect the doctor to disclose are those which a reasonable doctor would regard as 'real'. As noted in Chatterton,[50] this does not include the possibility of negligent performance. The doctor has to show that his or her behaviour in not disclosing the risk was legitimate, either because the risk was not real or because his or her professional colleagues would not have disclosed it. Evidence of either of these would satisfy the court that there was no negligence. To deal with the latter first, it was noted in Canterbury v. Spence[51] that there are known difficulties in obtaining evidence from a doctor or group of doctors which would indicate that a fellow professional had been negligent. Moreover, taking into account the terms of the Bolam test, it is not necessary to show that all doctors would support the position - only that a reasonable body of medical opinion would. Thus, even if one group of reasonable medical practitioners would have disclosed the information, the doctor who fails to make such disclosure will not be negligent if one other body of reasonable medical opinion would not have disclosed it. Since medical practice changes, and, as was said in Thake v. Maurice, '[o]f all the sciences medicine is one of the least exact',[52] then it is not unlikely that there will exist a body of responsible opinion which does not regard the failure to disclose as being in any way reprehensible.

Moreover, the courts have imported a further refinement of the standard required, which removes the assessment of what information needs to be disclosed even further from the actual patient in question, and which makes his or her allegation that he or she would have regarded the risks as 'real' or important subject to even more caveats. This further device equates broadly to the 'prudent' or reasonable patient test. In other words, not only is the doctor's behaviour judged in essence by what his or her colleagues have to say about what is acceptable medical practice, but there are further assumptions made both about what the reasonable patient would have known already, and about what he or she would have wished to know. In the case of Thake v. Maurice,[53] Nourse, L.J., portrayed both the court's role, and its dilemma, thus:

> The function of the court in ascertaining objectively the meaning of words used by contracting parties is one of every day occurrence but is often extremely difficult to discharge it where the subjective understandings and intentions of the parties are clear and opposed .... In the end, the question seems to be reduced to one of determining the extent of the knowledge which is to be attributed to the reasonable person standing in the position of the plaintiffs.[54]

In this case, the particular question hinged on whether or not the reasonable patient would have understood that tissues, once severed, as in a vasectomy, could regrow and rejoin, thus naturally reversing the effects of the sterilisation. The court accepted that it would not be rational to suppose that:

> ...a reasonable person standing in the position of the plaintiffs would have known that the vasectomy is an operation whose success depends on a healing of human tissue which cannot be guaranteed. To suppose that

> would be to credit him with omniscience beyond all reason.[55]

In this statement there seems to be some hope for the patient. The fact that the vast majority of medical acts involve technical information which the patient could not know without the implication of 'omniscience beyond all reason' might make it seem likely that failure to disclose such information would result in liability on the part of the doctor. However, the court immediately qualified this statement, and in so doing considerably undermined its significance for the patient. Nourse, L.J. continued:

> But it does seem to me to be reasonable to credit him with the more general knowledge that in medical science, all things, or nearly all things, are uncertain. That knowledge is part of the general experience of mankind, and in my view it makes no difference whether what has to be considered is some form of medical or surgical treatment or the excision, apparently final, of a section of the vas. Doubtless the general experience of mankind will acknowledge the certainty that a limb, once amputated, has gone forever. Such has been the observation from time immemorial of a species to whom the spectacle of war and suffering is commonplace. But where an operation is of modern origin, its effects untried over several generations, would a reasonable person, confronted even with the words and demonstrations of the defendant in this case, believe that there was not one chance in ten thousand that the object would not be achieved?[56]

Clearly, this question could readily be answered in the affirmative, although the judge chose to answer it in the negative. It is surely stretching what the reasonable patient might know, to suggest that it is common knowledge that, in effect, when parts of the body <u>are</u> cut to separate them, they can regrow - the example of the amputated limb which the judge himself introduced could, with respect, equally have served to reach the opposite conclusion. Moreover, it is not entirely clear at what point something becomes so routine or well tried that the reasonable patient knows or should know what are its chances of complete success. Indeed, the court may be thought to have introduced this as a rather unsubtle way of avoiding, or attempting to avoid, liability. Why, and indeed how, should the average patient have access to such information?

In this case, the judges seem to have become confused between whether or not a doctor guarantees the absolute success of therapy (which admittedly he or she does not, and cannot), and whether or not the risk of failure is known to the patient. There was no suggestion in this case that the parties would have rejected the therapy had they known the risk of failure, but rather that - had they been alert to this possiblity - subsequent difficulties and grief could have been avoided. In other words, the plaintiffs' subsequent freedom to make decisions and to avoid hazard, was severely affected by the failure to give them adequate information - information which would be demanded out of respect for their moral autonomy. In this case, damages were obtained but they were obtained rather on the basis of future limitation of freedom of choice and costs associated with this than on the basis of instant failure to disclose.

Sidaway v Bethlem Royal Hospital Governors & Others[57]

The impact of the Bolam test on the development of a theoretical position supporting or defending patients' rights to information has been substantial. However, it was open to a superior court to modify or overrule this test and to substitute an alternative. Indeed, in an article preceeding the Sidaway case, Robertson made what amounts to a plea for consideration of this very point.[58] As he said:

> Given that the duty to disclose is regarded as part of the overall duty of care, it seems likely that courts will be willing to accept that a doctor may be justified in withholding information concerning the risks of proposed treatment if he reasonably believes the performance of the treatment to be in his patient's best interests and the patient is likely to refuse the treatment if warned of the risks. This is a potentially far-reaching proposition which militates against the basic premise that the decision to undergo medical treatment should ultimately be that of the patient and not that of the doctor. It is hoped that it is a proposition that English courts will accept only in the most exceptional circumstances.[59]

Thus, it was hoped that the courts would only rarely ally themselves too completely to the interests of the professional group involved. After all, it would be scarcely surprising if doctors were not often to regard therapy as almost inevitably a good thing, or to view disclosure of therapeutic alternatives as unnecessary. To accept this, however, is to ignore the potentially opposing view of the patient who may - if fully informed of the likely risks of benefits and therapy - nonetheless wish to reject the treatment in question, or to accept a therapy which is not medically optimal.

The Bolam Test gives rise to the concern that the disinterested decision-making which can reasonably be expected in a court of law, will effectively be subject to control by the interested professional group, and that thereby the rights of the individual patient will take a poor second place to the interest of the doctor in exercising his or her clinical judgement. Whatever the motivation of the doctor, and however potentially beneficial the therapy, the choice is that of the patient, and it is for the law to set a standard which clearly takes account of patients' rights in this matter. Clearly, the Bolam Test is more concerned with professional consensus and standards than it is with the rights of any patient. Indeed, the therpeutic imperative was given substantial credibility by the court, as was the professional assessment of negligence.

The House of Lords, however, was recently given the opportunity in the Sidaway[60] case to pronounce once and for all on the nature and extent of disclosure which is legally acceptable, and on the rationale of rules about disclosure. The Bolam test could, if found wanting, have been modified or overruled, and emphasis placed firmly on patients' rights. Indeed, the court were well aware of the problems confronting them, having extensively consulted evidence from a number of jurisdictions and academic writings. Interestingly, the members of the court, whilst reaching the same conclusions as to liability, did so by different routes. Moreover, in the lower courts, the judgements were so varied that there was some difficulty in reconciling them to each other, and in reconciling some of the judgements to the ultimate decision.[61]

The Sidaway case presented unusual difficulties of proof, in that the physician whose behaviour was the subject of the complaint had died in the period between the source of the action and its resolution. Of necessity, therefore, the court was required to speculate on occasion, but this did not prevent Their Lordships from pronouncing clearly on the question of consent to medical treatment and the tests to be applied. From the perspective of the patient, the most supportive judgement was that of Lord Scarman, who - although not dissenting from the ultimate decision - nonetheless was prepared to go considerably further towards the Canterbury[62] test than were his colleagues. It is important, therefore, to consider the facts of the case, and the judgements in turn, since they now provide a clear statement of law for the United Kingdom as a whole, although courts may seek to distinguish this judgement.[63] Indeed, Brazier[64] claims that Sidaway has not finally settled the law in this area.

> The majority judgment of the Lords is by no means the end of the controversy over how much the doctor must tell. Indeed, all that this prolonged litigation may have achieved is that the transatlantic test that what the patient should be told should be judged by what the reasonable patient would want to know was rejected by the majority in the House of Lords.'[65]

The plaintiff, Mrs Amy Sidaway, suffered persistent pain in her neck and shoulders and was advised by her doctor (since deceased) that surgery on her spinal column offered the possibility of relief of the pain. The surgeon warned Mrs Sidaway of some, but not all, of the risks of the therapy. There were two risks specific to the surgery in contemplation. The first, concerned possible damage to the nerve roots in the area of the operation, and the second concerned possible damage to the spinal cord which might be slight or very serious. The estimated likelihood of either sort of damage occurring was statistically calculated by one witness as between 1% and 2%. However, if either risk did occur then the potential injury could be severe. The medical witnesses, whilst accepting that these were real risks of the operation, nonetheless assessed the likelihood of their eventuating as small, and in particular felt that the latter risk was even less likely to occur - estimated as being a probability of less than 1%.

In the event, however, the spinal cord was damaged and the plaintiff claimed that no warning had been given to her of the possible risk of this happening. Thus, the surgeon in question was alleged to have been in breach of his duty of care to Mrs Sidaway. In the unfortunate circumstances of the surgeon's death, it was only possible for the court to speculate as to whether or not he had in fact given a warning as to the possibility of this particular type of risk occurring. But the court was able to consider what the test of breach of duty in such cases should be, and this they did at some length. Lord Scarman's judgement represents the most radical approach and was considered by some to be a sign that the courts were opening up to protection of patients' rights. Lords Diplock, Keith and Bridge, however, presented a different picture, and one which is more clearly in line with earlier decisions. It is to their judgements that discussion will turn first, and thereafter consideration will be made of the extent to which Lord Scarman's opinion, had it been that of the majority, would have given priority to the rights of the patient.

It is also worth, at this point, distinguishing two separate strands of concern. To date, the discussion here has concentrated on the emphasis placed by negligence analysis on patients' rights'. This is, of course, a very substantial part of the overall picture. There is, however, one further important characteristic of the shift from assault to negligence which has so far not been considered in much depth, and that is the question of causation. This omission has been deliberate, and will be rectified later.[66]

For the moment, however, attention will be focussed on the first of these - that is, the manner in which the House of Lords defined the balance between patients' rights and doctors' duties, since this in fact the elementary stage at which attitudes are shaped. It is from this calculation that the first two aspects of the successful negligence action are firmed up - that is, the existence of the duty of care and the shape that duty takes. The causation element logically follows this.

It has been claimed that the Bolam Test shows scant regard for patients' rights - indeed, it could be said that if a right does emerge from this case it is equivalent to a 'right' to receive treatment. This is an area fraught with difficulty, and certain aspects of this so-called 'right to treatment' will be considered below.[67] For the moment it is sufficient to note that the therapeutic imperative took clear pride of place in the formulation of the Bolam Test.

In his judgement in the Sidaway case, Lord Diplock, in the first few sentences, seems to take the professional priority for granted. In his introductory remarks he seems to presume that decisions will be taken by doctors for their patients, noting that there are risks attached to all therapy, but that:

> All these are matters which the doctor will have taken into consideration in determining, in the exercise of his professional skill and judgement, that it is in the patient's interests that he should take the risk involved and undergo the treatment recommended by the doctor.[68](Emphasis added)

The fundamental assumption, therefore, would seem to be that it is for the doctor to weigh in the balance what risks the patient should be prepared to take in the interests of the possibility of improvement. [69]

Lord Diplock accepted that it was not certain whether or not the doctor in this case had weighed up these risks or whether or not he had passed them on to Mrs Sidaway, but in any event, these considerations were not regarded by him as having major importance or meriting serious consideration. In Lord Diplock's view there was one crucial piece of evidence on which he based his judgement, and this was, in line with the Bolam Test, the evidence of other doctors as to whether or not they would have disclosed the information of whose lack Mrs Sidaway subsequently complained. As he said, although the court did not know exactly what the particular doctor had done:

> What we do know, however, and this is in my view determinative of this appeal, is that all the expert witnesses specialising in neurology ..... agreed that there was a responsible body of medical opinion which would have undertaken the operation at the time the neurosurgeon did and would have warned the patient of the risk involved in the operation in substantially the same terms as the trial judge found on the balance of probabilities the neurosurgeon had done, i.e. without specific reference to risk of injury of the spinal cord.[70]

In other words, even although the trial judge was, in fact, in no position to decide what the doctor actually did, and even although his decision flew in the face of the evidence given by Mrs Sidaway, who was actually there to give evidence of what she had been told, the relevant factor was not whether or not the warning actually had been given, but the fact that the other expert witnesses would equally not have disclosed this risk.

Interestingly, Lord Diplock was vociferous in his praise for the Bolam Test on grounds which were scarcely under consideration in this case, where what was under consideration was whether or not disclosure of information had been made, and whether or not any lack of disclosure was negligent. However, courts seem to find the spectre of defensive medicine an irresistible tool in their decision-making in medical cases, and whatever its relevance (or lack of it) here, Lord Diplock asserted the importance of avoiding the 'American disease' in no uncertain terms. Moreover, he declined to draw any distinction between the exercise of technical skills and the exercise of others. As he said:

> In English jurisprudence the doctor's relationship with his patient which gives rise to the normal duty of care to exercise his skill and judgement to improve the patient's health in any particular respect in which the patient has sought his aid, has hitherto been treated as a single comprehensive duty covering all the ways in which a doctor is called on to exercise his skill and judgement in the improvement of the physical or mental condition of the patient for which his services either as a general practitioner or as a specialist have been engaged. This general duty is not subject to dissection into a number of component parts to which different criteria of what satisfies the duty of care apply such as diagnosis, treatment and advice (including warning of any risks of something going wrong, however skillfully the treatment advised is carried out).[71]

There are a number of interesting features of this assertion, not least that it follows immediately after a passage in which one is reminded that medicine changes and that we should not seek to inhibit such change. Might the law not equally require to modify itself to deal with novel and important situations?

In any event, the judge's refusal to separate the two distinct aspects of the doctor's duty - that is, on the one hand the use of his or her professional skills in diagnosis and identification of the appropriate range of therapy, and on the other hand the more human, and less technical, duty to respect the autonomy of another, by honestly placing the choices before the patient - bodes ill for any serious consideration of patients' rights.

Indeed, it seems - as did the Bolam case[72] - to suggest that, if the patient has a right at all, it is the right to be treated if the doctor thinks this is a good idea - no more than that. Where it is impossible, however, to disagree with Lord Diplock, is in his somewhat scathing account of the use of the concept of 'informed consent' which - as has been noted above - is generally so beset with caveats as to be rather meaningless. As Lord Diplock asked, what is the purpose of a doctrine of this sort when it effectively introduces the notion of the 'objective' or 'reasonable' patient, thus making the assumption that some risks, but not all, need be disclosed? As he enquired:

> On what logical or juristic basis can the need for informed consent be confined to some risks and not extended to others that are also real and who decides which risks fall into which class?[73]

This, of course, is an excellent question, but as a reason for applying the Bolam Test, it is scarcely convincing. The alternative for the House of Lords was not, and never was, the mere unthinking adoption of tests which Lord Diplock made quite clear were jurisprudentially foreign to English law. It is not beyond the capacity of the law to reject both tests and come up with another, and yet the tone of his judgement seems to suggest that adoption of one or other of the established tests was indeed the sole option he perceived.

In any event, Lord Diplock was unimpressed by the suggestion that it was possible to differentiate aspects of the doctor's behaviour into those which arise from his or her professional expertise, and those with which he or she is imbued because he or she is a person who has such expertise and therefore is the only person in the position to make explanations. This distinction he dismissed.

> To decide what risks the existence of which a patient should be voluntarily warned and the terms in which such warning, if any, should be given, having regard to the effect that the warning may have, is as much an exercise in professional skill and judgement as any other part of the doctor's comprehensive duty of care to the individual patient and expert medical evidence in this matter should be treated in just the same way.[74]

However, merely to assert that this is so does not make it so. Distinctions can be, and have been, drawn, to which Lord Diplock was apparently disinclined to attend. Moreover, hidden in these words is more than just a simple statement that the disclosure of information is a technical matter - a proposition which when put thus seems to lose some of its superficial credibility.

The decision as to whether or not to disclose information can only be regarded as part of the professional exercise of the doctor's skills as a doctor, if it is thought likely to have a significant impact on the patient's choice as to whether or not to accept the therapy - in fact, only if it is thought likely that the patient would not agree with the professional assessment made by the doctor that therapy should be undertaken. When seen in this light, the statement in effect is suggesting that, when the doctor thinks - in the exercise of his or her professional judgement - that the patient should undergo a particular therapy, then the patient should not be given the opportunity of declining it. In other words, the perceived value of therapy (even with the oft repeated caveat that it might not be successful) takes precedence over the patient's rights to reject therapy, however medically irrational this may seem, and to exercise his or her self-determination knowledgeably and in a calculated fashion. The same will apply to choices in respect of therapeutic alternatives.

Equally, it is submitted with respect, that the concurring opinions of Lords Keith and Bridge failed to distinguish between the exercise of technical, and other, aspects of the doctor's role. In referring with approval to the judgement in Hunter v. Hanley[75] that, '[i]n the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men ....',[76] and in applying this to the disagreement among the experts in this case as to whether or not the information would have been disclosed by them, the learned judges mistook the nature of information disclosure and the requirements therefor.

The test in Hunter v. Hanley[77] (that of failing to act as a doctor of ordinary skill acting with ordinary care) may be a sound basis for deciding technical matters, but it scarcely applies to non-technical ones. This is not to say that Lord Bridge, for example, does not recognise that alternative positions are tenable. There are, he noted, several possible options to be considered. As he said:

> It could be argued that if the patient's consent is to be fully informed, the doctor must specifically warn him of all risks involved in the treatment offered, unless he has some sound clinical reason not to do so. Logically, this would seem to be the extreme to which a truly objective criterion of the doctor's duty would lead.[78]

To dismiss this possibility, as Lord Bridge does, because it is not a feature of any jurisdiction to which the court was referred, seems somewhat disingenuous. However, neither was Lord Bridge prepared, at least overtly, to support what he saw as the opposite side of this extreme - that is, that doctors should not disclose information merely because to do so would alarm the patient. Unfortunately, not only does he fail to make a distinction between the technical and non-technical impact of a doctor's practice, even whilst accepting the importance of the patient's right to self-determination, but he then makes the fundamental mistake of assuming that the nature of the information to be disclosed is of a technical sort.

Indeed, there is a certain ambivalence in his judgement, which, paradoxically perhaps, makes it clear which of the interests under consideration is seen as being more valuable. Lord Bridge agrees that the prime matter for consideration is patient autonomy, and acknowledges its value, but considers its attainment to be served best by the clinical judgement of the instant doctor and his or her colleagues. Nonetheless, he has some sympathy with the court in the Canadian case of Reibl v. Hughes,[79] and expressly refers to what is perhaps one of the best known statements of the rights of patients in this area. In this case, Laskin, C.J.C. said:

> To allow expert medical evidence to determine what risks are material and, hence, should be disclosed and, correlatively, what risks are not material is to hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty. Expert medical evidence is, of course, relevant to findings as to the risks that reside in or are a result of recommended surgery or other treatment. They will also have a bearing on their materiality but this is not a question that has to be concluded on the basis of the expert medical evidence alone. The issue under consideration is a different issue from that involved where the question is whether the doctor carried out his professional activities by applicable professional standards. What is under consideration here is the patient's right to know what risks are involved in undergoing or foregoing certain surgery or other treatment.[80]

In his judgement, Lord Bridge apparently fully appreciated the force of this reasoning, but then introduced a <u>caveat</u> which in effect so dilutes the reasoning purportedly accepted as to make it significantly different. This <u>caveat</u> is that of 'clinical judgement' and is described by Lord Bridge as '..... a decision what degree of disclosure of risks is best calculated to assist a particular patient to make a rational choice whether or not to undergo a particular therapy.....'[81] Thus, he concludes, the <u>Bolam Test</u> is the appropriate basis for decision-making.

This can only be the case if two pre-suppositions are accepted, which at no stage appear in the reasoning of Laskin, C.J.C., a judgement with which Lord Bridge nonetheless claims to be in sympathy. First, it is necessary to accept that the issue is the exercise solely of technical professional skills when assessing the acceptable level of disclosure. If the argument presented by Laskin is in fact accepted, then, whilst medical evidence may contribute to the test of materiality, it is the patient's right that is definitive of it.

Further, Lord Bridge assumes the necessity of making a rational choice. It has been said above[81] that rationality need not be a definitive criterion when the patient's right to self-determination is being protected, and this need not be rehearsed again here. However, it is worth considering the extent to which 'rational' in this context, and subject to these tests means 'personally rational' or 'medically rational'. If clinical judgement can be used to withhold information, then one must ask why? Presumably this is so because it might distress the patient, or might put him or her off the therapy which the doctor regards as being appropriate.

Now, the self-determining patient might well regard his or her distress at certain types of possible risk as being highly relevant to the making of a personally rational decision, yet the court seems to be suggesting that, rather than that possible distress forming an important aspect of the decision, it should simply be avoided. Equally, if the risks associated with the medical choice are such that they might deter the patient from undertaking the therapy, then it is not necessarily irrational to choose not to undertake them. What is referred to as being 'rational', then, would seem to be what is <u>medically</u> rational - in other words, what has been referred to earlier as the therapeutic imperative. Thus, in this judgement apparent sympathy with Laskin's viewpoint merely serves to disguise the underlying value given to medical choice and medical judgement.

Lords Diplock, Keith and Bridge were in substantial agreement that the <u>Bolam Test</u> - presuming as it does the supremacy of medical judgement, and assuming the disclosure question to be one which is merely an aspect of the doctor's overall duty of care to his or her patient - was the appropiate test to use in such cases.

Lord Templeman reached substantially the same conclusion, but by a somewhat different route. He placed considerable emphasis on the fact that the reasonable patient could be expected to know that major surgery was potentially risky, and also on the skill of the doctor in balancing the risks and benefits and coming up with a recommendation which was in the patient's best interests. He accepted that the ultimate decision was that of the patient, but emphasised that this did not mean that the patient should be told of all the risks. As he put it:

> The relationship between doctor and patient is contractual in origin, the doctor performing services in consideration of fees payable by the patient. The doctor, obedient to the high standards set by the medical profession, imliedly contracts to act at all times in the best interests of the patient. No doctor in his senses would impliedly contract at the same time to give to the patient all the information available to the doctor as a result of the doctor's training and experience and as a result of the doctor's diagnosis of the patient. An obligation to give a patient all the information available to the doctor would often be inconsistent with the doctor's contractual obligation to have regard to the patient's best interests.[83]

It is submitted that this last sentence is both an overstatement, and a serious misunderstanding of the best interests of the patient. It may be true that, on occasion, information may cause the patient more suffering, and indeed one writer has suggested, that in such cases, disclosure of that information could itself amount to a kind of negligence.[84] However, to suggest that this is often or routinely the case is to translate mere speculation into legal principle, and is also to reinforce the suggestion that distress caused to the patient by the possibility of the occurrence of a particular risk is not relevant to the decision, when in fact in some cases it may be the crucial and legitimate determinant of the patient's choice. Moreover, Lord Templeman also seems to imply that the best interests of the patient will 'often' be impeded by disclosure, apparently assuming that the medical choice will generally be in the patient's best interests - but how can this be so if a risk occurred which would have deterred the patient from therapy in the first place?

Although couched in slightly different terms from his colleagues, Lord Templeman's judgement also introduces a particular view of the nature of the choice that the patient is entitled to make. As Lord Bridge referred to 'rational' choices, so Lord Templeman considered that information disclosure should be constrained by the need to obtain 'balanced' choice.[85] But, this 'balance' seems heavily weighted in favour of medical choice, although it is apparently conceded that the patient may make a choice which is not 'balanced'. In viewing the issue from the perspective of the doctor's duty it is, of course, not illogical to suggest that the major criterion should be the exercise of the doctor's skills in restoring, or seeking to restore, health.

However, if seen from the perspective of patient autonomy, then the choice as to whether or not the chance of restoration of health is worth the risks entailed by therapy is not a medical one but a highly personal one, which cannot effectively be undertaken without information.

However, in the nature of the negligence action, it is the doctor's duties which are under consideration, and the patient's rights seem to play a secondary role. Lord Templeman, regarding the primary good as the restoration of the patient's health, put the test to be applied thus:

> In order to make a balanced judgement if he chooses to do so, the patient needs to be aware of the general dangers and of any special dangers in each case, without exaggeration or concealment. At the end of the day, the doctor, bearing in mind the best interests of the patient and bearing in mind the patient's right to information which will enable the patient to make a balanced judgement, must decide what information should be given to the patient and in what terms that information should be couched.[86]

Whilst not expressly approving the Bolam Test, this latest formulation of the doctor's duty does nonetheless countenance deliberate non-disclosure of information, and indeed justifies it. Moreover, the clinical judgement of the doctor will seldom be readily open to challenge, and therefore his or her view of what information is necessary for the patient to make a balanced judgement will necessarily be given considerable weight. This test, therefore, also implies that the doctor is the primary guardian of what would be a balanced judgement by a given patient and effectively precludes argument as to the doctor's assessment, since if it is made in good faith, and in what the doctor (and his colleagues) believe to be the best interests of the patient, the fact that the decision for therapy subsequently turns out to have harmed the patient - and, it could be argued, was therefore not in his or her best interests - is not relevant.

From the patient's perspective, perhaps the most reassuring judgement was that of Lord Scarman, who, although agreeing with the final decision of the court on this particular set of facts, nonetheless took a radically different view of the fundamental issue for concern. Whilst Lord Templeman did not expressly accept the Bolam Test, neither did he expressly reject it, and it could be argued that the effect of his approach would, in any event, be roughly similar. Lord Scarman, in urging his colleagues to an acceptance of the Canterbury Test,[87] seems, however, to be giving primacy to the rights of the patient rather than being prepared to accept conventional medical wisdom as determinative of the issue. Although his view did not prevail, his reasoning is nonetheless worthy of consideration. Lord Scarman started from the question as to whether or not the professional test, which is used in assessing matters of professional skill, was indeed the appropriate test in matters of disclosure. He indicated that, if the professional test was deemed appopriate, then:

> The implications of this view of the law are disturbing. It leaves the determination of a legal duty to the judgement of doctors .... It would be a strange conclusion if courts should be led to conclude that our law, which undoubtedly recognises the right of the patient to decide whether he will accept or reject the treatment proposed, should permit the doctors to determine whether and in what circumstances a duty arises, requiring the doctor to warn his patient of the risks inherent in the treatment which he proposes.[88]

Moreover, and in direct contrast to Lord Diplock's view, Lord Scarman could see no reason why novelty should be a bar to contemplating legal change. As he said:

> The common law is adaptable. It would not otherwise have survived over the centuries of its existence .... It would be irony indeed if a judicial development [that is, the negligence action] for which the opportunity was the presence in the law of a flexible remedy should result now in rigidly confining the law's remedy to situations and relationships already ruled on by the judges.[89]

This was a significant aspect of Lord Scarman's judgement because, even although the <u>Canterbury Test</u> may be subject to its own difficulties, the possibility of amendment and modification of judicial reasoning in such cases remained open if his view was adopted. As he put it:

> If, therefore, the failure to warn a patient of the risks inherent in the operation which

> is recommended does constitute a failure to respect the patient's right to make his own decision, I can see no reason in principle why, if the risk materialises and injury or damage is caused, the law should not recognise and enforce a right in the patient to compensation by way of damages.[90]

Lord Scarman, in approving the Canterbury Test, and rejecting the Bolam Test, provides his own formulation of the nature of the enterprise.

> It is a sound and reasonable proposition that the doctor should be required to exercise care in respect of the patient's right of decision. He must acknowledge that in very many cases factors other than the purely medical will play a significant part in his patient's decision-making process ..... The doctor's duty can be seen, therefore, to be one which requires him not only to advise as to medical treatment but also to provide his patient with the information needed to enable the patient to consider and balance the medical advantages and risks alongside other relevant matters, such as, for example, his family, business or social responsibilities of which the doctor may be only partially, if at all, informed.[91]

Throughout this entire case this remains the single suggestion that there are matters other than the purely medical which might be of sufficient weight to affect decisions about therapy, and is the only profferred standard which values the patient's personal considerations equally with the medical. To this extent, it represents a radical departure from the views of previous courts, and indeed from those of his colleagues.

This is not to say, however, that Lord Scarman would decide the issue without reference to medical opinion, merely that he would not give it the primacy that it seems otherwise to have. Again, this view is very much in line with the Canterbury Test which, in his view, provides a good standard, since:

> Without excluding medical evidence they set a standard and formulate a test of the doctor's duty, the effect of which is that the court determines the scope of the duty and decides whether the doctor has acted in breach of his duty.[92]

Indeed, Lord Scarman was fulsome in his praise for the Canterbury test referring to it as, '...... a legal truth which too much judicial reliance on medical judgment tends to obscure.'[93] And he continues, differentiating the technical from the non-technical:

> In a medical negligence case where the issue is as to the advice and information given to the patient as to the treatment proposed, the available options and the risk, the court is concerned primarily with the patient's rights. The doctor's duty arises from the patient's right. If one considers the scope of the doctor's duty by beginning with the right of the patient to make his own decision whether he will or will not undergo the treatment proposed, the right to be informed of significant risks and the doctor's corresponding duty are easy to understand, for the proper implementation of the right requires that the doctor be under a duty to inform his patient of the material risks inherent in the treatment.[94]

Unfortunately, this seemingly unequivocal assertion of the patient's rights is, as in Canterbury[95] itself, in

Lord Scarman's view also, subject to the exception of therapeutic privilege which can effectively limit the nature and extent of the disclosure which the doctor must, in practice, make.

Equally, Lord Scarman recognised that the decision as to what is a material risk should ideally be based on what was material to the given patient. This, however, he ultimately rejected as being Utopian, preferring the equivalent of the 'prudent patient' test. However, whilst accepting that this permits considerable opportunity for the reintroduction and re-emphasising of medical evidence, Lord Scarman nonetheless maintained the view that the ultimate decision remains legal and not medical. The extent to which it is Utopian to regard it as a possibility or a probability that medical evidence would be discounted in these circumstances, and that the court would effectively condemn an established medical view, remains open, since unfortunately Lord Scarman was content to rest there.

In any event, even if the court did make such a radical departure from its general practice, Lord Scarman holds out one further possible defence for the doctor. That is, '...the defence that he reasonably regarded it to be against the best interests of his patient to disclose....'[96] Thus, from the apparently definitive commitment to the rights of the patient, what remains is a vague rule with a series of exceptions, which render the general rules significantly less meaningful.

## Summary

The Sidaway[97] case has been considered in considerable detail for the main reason that it must now represent the law of England, and would certainly be taken as highly influential in Scotland, given that it is a decision of the House of Lords, which is clear and unequivocal in its majority terms.[98] What then are the implications of the application of this judgement for the claim, accepted by all of the judges, that the patient does indeed have rights in the medical enterprise to decide on whether or not therapy recommended by his or her doctor should be accepted? It is submitted that the adoption at the highest level of the Bolam Test renders it virtually impossible for the patient to succeed in claiming damages where the assertion is that his or her decision was based on inadequate disclosure of information. Part of this submission relates to the kind of proof demanded of the patient in such cases, and part to the question of causation.

In terms of the Bolam Test, the patient, in order to succeed, would need to establish that no responsible body of medical opinion would have withheld the information which was withheld in the present case. Not, it should be noted that there is a body of responsible medical opinion which would support the patient's claim that the information should have been disclosed, a task - given the differences of opinion demonstrated in the Bolam[99] case itself - in which it would by no means be impossible to succeed. The test, on the contrary, demands only evidence that there is a responsible body of opinion which would have supported non-disclosure, and if this can be found the patient's case falls. Given the fact that cases are seldom defended unless there is expert evidence to support the doctor,[100] the patient will almost inevitably be faced with just such a body of opinion.

Moreover, the difficulties of finding professionals who would be critical of their colleagues is well known, and has been discussed above. In any event, the patient may find it difficult to find a doctor willing to say in a court of law, that he or she would have acted in a manner different from his or her professional colleague. The emphasis on clinical judgement, and the primary assumption that the doctor will inevitably act in good faith and in the best interests of his or her patient, renders the difficulty of proof even more substantial. In fact, only those cases which amount to a gross failure to disclose, and which would, in any event, following Chatterton v. Gerson,[101] have the potential to be raised in assault, would be likely to be susceptible of the kind of proof which the patient is required to show in terms of the Bolam Test.

## Causation

Even assuming that such evidence could be made available, and that the case continues to be heard under the aegis of the negligence action, there remains one further test. As in all allegations of negligence, it must be shown that the negligent act caused the harm complained of - that is, there remains the question of causation. At first sight, this may seem relatively unproblematic. In general, causation is established by the fact that had the person not been negligent then the harm would not have occurred. In questions relating to disclosure, however, it can be extremely problematic.

If a risk is inherent in a given therapeutic or diagnostic procedure, then its disclosure to the patient may render the doctor non-negligent, but it could not by definition be avoided. Conversely, the negligence of the doctor who does not disclose the risk is less clearly capable of correlation to the harm which occurred, since it could have occurred in any event. Indeed, the only clear link here would be if the disclosure resulted in every case in the patient rejecting the therapy - a situation which is clearly ridiculous. In other words, therefore, the link between non-disclosure and the eventuation of harm is somewhat tenuous.

For this reason, the patient must rely on showing that he or she <u>would</u> in fact have rejected the medical act had the information been disclosed and this may be extremely difficult to do. Whilst the patient may well allege that, had he or she been informed of the possibility of the risk which in fact eventuated, then the therapy would have been rejected, as the court noted in Canterbury v. Spence,[102] there are difficulties in deciding against what kind of test such an assertion should be measured. It is thought to be too easy for the patient to act with hindsight, and in the face of what could amount to a severe disability, and therefore to suggest that he or she would not have consented. Therefore, yet one more test has to be imposed, whether or not overtly, in assessing not merely the credibility of the witness, but also the likelihood of disclosure of the risk actually having deterred the patient from proceeding with the therapy. As Robertson notes:

> In testing the plaintiff's credibility and reliability (since the patient himself may have difficulty in deciding retrospectively whether he would have undergone the treatment despite the risks) the court will have to introduce a certain degree of objectivity. Thus, the extent to which the treatment was truly 'elective' and the magnitude and nature of the risk involved are likely to be crucial factors in determining whether or not the patient would have consented to the treatment had he been informed of the risk.[103]

Thus, the court will not address itself to the issue of whether or not this particular patient would have agreed to therapy knowing the risks, but rather to the question of whether or not it would have been reasonable for him or her to attach significance to them. In making such judgements the court will, of course, have some concern for the credibility of the witness/patient, but since the court is also charged with establishing the duty of the doctor, it will necessarily also be interested in an assessment of whether or not the doctor was negligent in his or her assumptions about the need for disclosure. In other words, there is a clear Catch 22.

On the one hand, the courts will allow that the doctors can, in the exercise of clinical judgement, decide (without being negligent) that a particular risk may deter a patient from therapy or cause unnecesary distress, and yet on the other, it purports to make an objective assessment of whether or not the risk would have been relevant to the patient's decision and therefore should have been disclosed. In other words, if the doctor acted in good faith, and in accordance with a professionally acceptable standard, in not disclosing the risks, how - in terms of the negligence action, as limited in particular by the Bolam Test - could the court subsequently agree that the patient would not have gone ahead had the risk been disclosed, thereby establishing the element of causation? Given the combined use of therapeutic privilege and clinical judgement, the patient seems to be in an impossible position, even assuming that there is evidence that no responsible body of medical opinion would have withheld information about the risk.

Quite apart from this problem, of course, the court - which is as removed from the patient as is the doctor - will effectively substitute its own view of what the 'reasonable patient' would have regarded as an acceptable risk for the view of the doctor or the patient. Thus, whatever the patient says, if the judge in question would not have regarded the risk as unacceptable (and this calculation may be based on statistics, or on a judicial view of the patient's postion, or mere personal bias) then it is unlikely that the link between non-disclosure and the ultimate damage will readily be established. Of course, if the likelihood of the risk actually occurring is particularly remote (statistically) then it may be difficult to claim that it is more than a mere fluke, thus rendering a common sense view of what causation is rather more difficult to satisfy. In any event, it can be seen that the use of the Bolam Test makes it unlikely that courts will have to consider this question, since the difficulties of establishing that the duty of care was in fact breached are on their own almost insurmountable. Whatever the problems with the Canterbury Test, it at least permits of the possibility, if not the probability, of success.

Moreover, causation may be further complicated by the fact that harm must be shown. Where the treatment did not harm the patient, and the patient is rather complaining about the denial of a right to make a choice, this last must be a recognised and distinct right, breach of which is understood as causing legally recognised harm.[104] The patient who has sustained damage (physical) will at least be able to point to this - it is measurable and undeniably equates to legal harm. However, the patient who complains of an insult to integrity is claiming compensation for a harm which will only be recognised if the right to self-determination in medicine is accepted as a legally vindicable interest. Of course, physical harm is not the only basis on which compensation may be successfully sought. As Winfield and Jolowicz[105] puts it:

> In the law of tort, there is a growing body of case law where negligent defendants have been held liable even though they have not injured the plaintiff or his property by any positive act and where their conduct seems most naturally expressed in terms of failure to ensure the receipt of expected benefits.[106]

Although an intensive analysis of the heads of damages is not within the scope of this discussion, the point that legal recognition of the type of harm is crucial to the availability of compensation, cannot be ignored. This serves to distinguish further between the value of actions in trespass/battery/assault and those raised in negligence.As Winfield and Jolowicz[107] further notes:

> Whereas most torts require damage resulting to the plaintiff which is not too remote a consequence of the defendant's conduct, a few, such as trespass in some, or perhaps all, of its various forms and libel, do not

require proof of actual damage.'[108]

## The Enquiring Patient

Courts in both the United States and the United Kingdom, therefore, seem prepared to accept that the decision as to what information should be disclosed is substantially a matter of medical judgement. The extent to which medical opinion plays a decisive role varies from the rather tentative assertion of patients' rights in Canterbury,[109] to an outright commitment to reasonable medical practice in Bolam[110] and Sidaway.[111] Equally, in no case is it suggested that all information should be disclosed, albeit that this is based not on principle but on practicality. The most commonly used rationale is as follows: The 'average' patient can be assumed to know that therapy (and particularly surgery) carries with it an element of risk. Only those risks special to the particular therapy, and decided (by the doctor) to be real or material need be disclosed. This limitation is justified on the practical basis of the difficulty of disclosing all risks, and on the more esoteric one that doctors can legitimately decide that it is not in their patients' interests to know certain information.

Courts, therefore, in adopting this approach, are in a postion to speculate in a manner in which they apparently regard as unacceptable in other aspects of decision-making. In the recent case of <u>Blyth</u> v. <u>Bloomsbury Health Authority</u>,[112] the patient - a trained nurse - was deemed to require less careful warnings since she might be presumed to know of the medical indications of an adverse reaction to therapy. Whether or not she <u>actually</u> knew this information was apparently less relevant than the fact that she <u>could</u> have. Has the position now been reached where there is a 'specialist patient' test?

In any event, if it is true that the withholding of information can be in the patient's best interests, then would this not be true whatever the situation of the patient? In particular, would it not remain true whether or not the patient asks for the information? Here, the fallacy of this type of justification for non-disclosure becomes clear. Indeed the most consistent judicial approach is to be found in the judgement of Lord Denning in the case of <u>Hatcher</u> v. <u>Black</u>,[111] a decision which is so open to criticism as to be routinely rejected. In this case a doctor deliberately answered a direct and straightforward question about a particular type of risk, falsely. Lord Denning held the doctor to be entitled so to do 'in the best interests of the patient', on the assumption that had the risk been dislosed, and had the doctor then been forced to disclose the existence of alternative therapy which did not carry this risk, the patient might have rejected the doctor's choice of treatment. Whilst morally open to question, this decision is at least consistent with the contention that the doctor is entitled to withhold information on the basis that it would distress the patient, or deter him or her from therapy - whether or not questions are asked.

However, the majority of American and British decisions make precisely this distinction between the patient who asks questions and the patient who does not. It is paradoxical that there seems to be more concern about the doctor actively lying to the patient than there is about the doctor who presents a false picture by omission. Blyth[114] ties the 'specialist patient' intimately to the enquiring patient. As was said:

> As the plaintiff was in my judgement, seeking information and as she was someone with nursing qualifications who could be trusted not to act irrationally because of what she was told, she was, in my opinion, entitled to be given such information as was available to the hospital.[115]

There are a number of interesting and interlinking strands to this statement. In the first place it would seem that it was the qualification of the patient (herself medically oriented) which entitled her to the information, presumably on the assumption that she would nonetheless have opted for the medical recommendation. Equally, the fact that she asked a straight question (which might, of course, be possible only where some medical information is already known) meant that she acquired rights, even to potentially distressing information, which would be denied in other circumstances. The view that the enquiring patient should be answered honestly by the doctor, and should be given the information which the doctor would otherwise have been legally and professionally justified in withholding, is paradoxical. Yet, it also has received wide support. Although dismissed out of hand in Canterbury,[116] it is generally accepted as an exception to the rule that the doctor is the master of the instance.

Whilst it may seem morally satisfying that a patient who asks questions should be told the truth and not a lie, this merely begs the fundamental question. If courts would otherwise have upheld non-disclosure, as seems almost certain, then there must presumably be good grounds for so doing. These grounds are legally accepted as being that it is not in the patient's interests to know this information. How, then, does it become in the patient's interests merely because the question occurs to him or her, perhaps fortuitously? In truth, of course, the 'average' patient consults a doctor because he or she does not have access to certain information. In view of this, it is unlikely that the patient will know what questions to ask of the doctor, and yet if he or she does stumble on the right question, there is an immediate (albeit extremely random) attribution of rights to which their fellow patients are not entitled.

Of course, it could be said that the fact that the patient asked a particular question about a possible risk is not dependent on medical knowledge, since it has been argued that the information to be disclosed is personal rather than technical. Thus, if it is true that the patient should be told of risks, and that these risks are not merely technical risks, then the ordinary patient will ask the right questions because no medical knowledge is necessary to the formulation of the question, or concern about the particular risk. However, this argument is somewhat naïve, since in truth the likelihood of, for example, drug therapy resulting in brain damage or paralysis is scarcely within the contemplation of the patient, although it may be known to the doctor in respect of a particular drug. The patient can, of course, appreciate the impact on his/her life of the risk of brain damage, but it would take some technical skill or knowledge for him or her to think of asking the question. In any event, the patient is under no duty to question, since the doctor is the party with duties in the medical enterprise. Patient distress, so convenient a reason for non-disclosure is more validly used as an issue when assessing whether or not the patient who has no medical knowledge and may be suffering from a distressing illness should also be expected, if his or her rights are to be vindicated, to ask the right question. To rely on this would certainly be morally unacceptable, and would be to discriminate between the aggressive or assertive patient and the patient who is cowed by involvement in the medical enterprise, or by the fact of illness. Verbal acuity, or personal confidence, scarcely seem sound reasons for the attribution of specific and significant rights. Yet, courts seem happy to make the assumption that the patient does become entitled to more (even distressing or deterring) information, merely because they have the nous to have asked for it.

In the <u>Sidaway</u>[117] case, for example, the enquiring patient was singled out for special consideration by some of the judges. Indeed such differentiation was also significant in the <u>Bolam</u>[118] decision which they followed by a majority. As MacNair, J. put it:

> Having considered [the evidence on this point], you have to make up your minds whether it has been proved to your satisfaction that when the defendents adopted the practice they did (namely, the practice of saying very little and waiting for questions from the patient), they were falling below a proper standard of competent professional opinion on this question of whether or not it is right to warn.[119]

In <u>Sidaway</u>, Lord Diplock, for example, also draws such a distinction:

> ... when it comes to warning about risks, the kind of training and experience that a judge will have undergone at the Bar makes it natural for him to say (correctly) it is my right to decide whether any particular thing

> is done to my body and I want to be fully informed of any risks there may be involved of which I am not already aware from my general knowledge as a highly educated man of experience, so that I may form my own judgement whether to refuse the advised treatment or not. No doubt, if the patient in fact manifested this attitude by means of questioning, the doctor would tell him whatever it was the patient wants to know ....[120]

Leaving aside the question as to whether or not only 'highly educated' people can correctly say they have a right to make choices about what is to be done to their bodies, there remains no justification for distinguishing between the person who asks and the person who doesn't. If rights are attributed because the person is entitled to respect for his or her self-determination, then only stringently applied and compelling reasons would justify invasion. Failure to ask a question, which in any event lack of technical information may preclude one from having the capacity to formulate, can scarcely be regarded as a legitimate basis for the withholding of information which may have a significant impact on the capacity to exercise the right of self-determination. Although differing in the basis of his decision from the majority, Lord Templeman also drew a similar distinction.

> Mrs Sidaway could have asked questions. If she had done so, she could and should have been informed that there was an aggregate risk of between 1% and 2% of some damage either to the spinal cord or to a nerve root resulting in injury which might vary from

irritation to paralysis.[121]

It is arrogance indeed to claim on the one hand that the patient is likely to act irrationally if all information is disclosed, or that the doctor should avoid telling the patient of risks which might upset him or her, and yet, on the other hand, to demand that, in order to maintain his or her capacity to make self-determining choices, the patient is virtually under an obligation to ask relevant and specific questions. But it is not altogether unusual to find courts demanding just such standards from patients. This point was raised approvingly in, for example, O'Malley-Williams v. Board of Governors of the National Hospital for Nervous Diseases,[122] and the same distinction was drawn in Lee v. South West Thames A.H.A.[123]

At least one Canadian case has further refined this test, and since it seems to be completely in line with the attitude of British courts it is worthy of consideration as likely to be supported. In describing the doctor's duty of disclosure in the case of of Lepp v. Hopp,[124] the court explained it thus:

> The law draws a distinction between the general duty of disclosure imposed on a surgeon when he is obtaining a patient's consent to surgery and the duty of disclosure he is under when he responds to specific questions from his patient ... When specific questions are directed to the surgeon he must make a full and fair disclosure in response to them. This duty requires the surgeon to disclose risks which are mere possibilities

> if the patient's questions reasonably direct the surgeon's attention to risks of that nature <u>and if they are such that the surgeon, in all of the circumstances, could reasonably foresee would effect the patient's decision.</u> [125] (Emphasis added).

In other words, not only the non-enquiring patient, but, to a lesser extent perhaps, even the enquiring patient, will be subject to the doctor's assessment of whether or not a risk would be material to the patient him or herself.

In any event, as Robertson points out,[126] both this and other similar decisions (such as <u>Smith</u> v. <u>Auckland Hospital Board</u> [127]) rely on an arguable interpretation of the rule in <u>Hedley Byrne & Co. Ltd.</u> v. <u>Heller & Partners Ltd</u>.,[128] which permits the person who is asked questions the option of silence. Robertson argues, however, that the doctor/patient relationship differs from the standard contractual one in a significant and determinative manner - that is that there is a pre-existing duty of care on the doctor which 'deprives the doctor of the "option of silence" and which requires him to answer the question with reasonable care.'[129]

It is, therefore, a highly dubious proposition that the patient who asks questions is entitled by this mere fact to additional autonomy-enhancing information. Were the truth or dishonesty of the doctor the central issue, then failure to answer a direct question might well take on a major significance. However, what is at issue here is a far greater consideration - that of the patient's right to self-determination, and this cannot be dependent on the patient having sufficient preliminary knowledge, or even plain courage, to ask the right question, nor on his or her capacity to challenge or question medical authority. As Robertson says, '[t]he law should seek to ensure that, in relation to disclosure of risks inherent in proposed treatment, the onus lies with the doctor and not with the patient.'[130] To this end, the view of the court in Canterbury v. Spence[131] bears repetition and consideration. The court said:

> We discard the thought that the patient should ask for information before the physician is required to disclose. Caveat emptor is not the norm for the consumer of medical services. The duty to disclose is more than a call to speak merely on the patient's request or merely to answer the patient's questions; it is a duty to volunteer if necessary, the information the patient needs for an intelligent decision.[132]

There is yet one further aspect of medicine in which information disclosure is critical, and it merits consideration as a separate issue since it shows evidence of some difference in emphasis which apparently relates, perhaps not surprisingly, to the nature of the enterprise. This area is the experimental use of treatment either in pursuit of an immediate therapeutic goal, or in the wider context of research for scientific knowledge. Although the complexities of experimentation and concerns about scientific method, are very significant issues, a detailed analysis of them lies beyond the scope of this discussion.[133] However, some consideration can briefly be made of the protection offered to patients' rights in novel or experimental situations.

## Experimentation

The principles governing human experimentation can be found in the Declaration of Helsinki, promulgated by the World Medical Association.[134] The Declaration makes it a prerequisite of professional care in the experimental situation that the doctor should '[i]f at all possible, consistent with patient psychology, .... obtain the patient's freely given consent after the patient has been given a full explanation.'[135] In this situation (therapeutic research) the aim is to provide benefit to the patient by the use of alternative or innovative therapy. The motivation of the doctor and the aim of the intervention are exactly the same as in the routine medical interaction, the difference being only that the therapy is relatively untested, or untested on that particular condition. In non-therapeutic research, where the aim is the advancement of knowledge, the Declaration is even more firm, demanding that 'the nature, the purpose, and the risk of clinical research must be explained to the subject by the doctor,'[136] and continuing, '[c]linical research on a human being cannot be undertaken without his free consent, after he has been fully informed ....'[137]

The patient, therefore, is offered clear protection from unwilling or unknowing involvement in research or experimentation, even where the choice of radical or new therapy is thought to be directly for his or her benefit. The Declaration - particularly in that part dealing with non-therapeutic research - makes clear and unequivocal statements recognising the rights of the subject to exercise his or her power of choice, and to respect for his or her 'personal integrity'.[138] Thus, the morality of experimentation is seen to depend heavily on the patient being given the opportunity, through information, to exercise choice. The unwilling or unknowing patient will not, therefore, be a participant in either therapeutic or non-therapeutic research - in recognition of precisely those rights which, it has been claimed above, pertain in all medical situations.[139]

Advances in therapy are seen as desirable - by doctors and patients alike. No advances, it is claimed, are likely without experimentation[140] and ultimately this requires human subjects. Species differences mean that, even after full laboratory and animal testing, there must be a human 'guinea-pig' before the effect on humans of a new therapy can be truly known.[141] Like medicine itself, then, experimentation - with its potential for advances in both instant and long-term patient care - is generally regarded as 'good'.

However, although it has been said earlier that orthodox medicine and its techniques are routinely not questioned, and are substantially left to the judgement of doctors themselves, there are aspects to the use of human beings in the experimental situation which are widely perceived as differentiating it from other medical events. This perception has arisen most forcefully from the well-documented programmes of the Nazi doctors in the course of the Second World War.[142] The international outcry which followed exposure of their callous use of human beings was such that experimentation itself became seen as a potentially dubious enterprise. As a result of this, the status of the individual human being in experiments became a matter of considerable concern, as can be seen from the strong terms of the Declaration of Helsinki. Whether therapeutic or non-therapeutic, the use of human subjects in medical experiments generated strict moral codes reflecting the rights of the individual, and guaranteeing these rights as of primary significance.

Thus, medicine itself was prepared to acknowledge the moral status of the patient - at least in this situation - unequivocally and firmly. Indeed, the main control of experimentation in the United Kingdom comes substantially from medicine itself,[143] not because of a belief that doctors will in fact behave in the same way as did the Nazi doctors, but as a reaffirmation of the rights of the individual and the duties of the doctor in protecting these rights. The Declaration of Helsinki, as an international, and thereby effectively unenforcable, set of guidelines, provides merely the broad framework within which experiments can be carried out. As a truly effective moral code it has a number of obvious failings, notably the <u>caveats</u> concerning consent,[144] but it does perform an important symbolic function in protecting the status of the individual, in reminding doctors of the need to make full disclosure of risks and benefits, in demanding the careful weighing up of benefits which they hope to obtain against the possible risks to the patient, and of the dependent nature of the doctor-patient relationship which makes it easier for the doctor - without necessarily having any intention so to do - to command the consent of the patient because of the trust with which he or she is invested by the patient.[145]

In recognition of these possible difficulties, this remains one of the best policed areas of medical practice - interestingly, substantially policed by the profession itself, rather than the law. The recommendations of the Royal Colleges,[146] which resulted in the setting up of Research Ethical Committees in all hospitals where research is undertaken, were entirely motivated by the medical profession, and despite merely being recommendations, and therefore not legally enforcable, all hospitals undertaking research now have such Committees. In theory at least, these Committees satisfy many of the constraints which it might seem desirable to place on medicine in its role as scientific experimenter. The function of the Committees is to scrutinise research proposals, not merely for their clinical potential but also for their morality and the ethics of the way in which they are conducted.[147] This is done, not solely to protect medicine, but rather to protect the patient. Even more significantly, these Committees are to have lay representation,[148] an acknowledgement of the fact that decisions may not necessarily be good merely because they are taken by expert clinicians.

In the United Kingdom, the law's practical intervention has been dependent on the type of experimentation. Case law has adapted to deal with therapeutic innovation,[149] whilst statute covers products associated with medicine which require clinical trials.[150] The Medicines Act 1968 established the Committee on Safety of Medicines[151] which has, amongst other responsibilities, the task of scrutinising and ultimate decision-making in respect of clinical trials (experiments) of new pharmaceutical entities. Although the operation of both Research Ethical Committees and the Committee on Safety of Medicines has been criticised,[153] their existence has not. Indeed, their existence and functions represent the clearest possible statement of the value to be attached to the human subject. Given these safeguards, and the code of ethics which doctors are expected to follow, the doctor who comes to his or her patient seeking involvement in experimental procedures, has arguably been already required to consider in more depth than usual the implications of the proposed intervention. It might seem, therefore, that there is no additional need for rules about consent.

The proposed action, in therapeutic experiments is, like all medical intervention, designed to help the patient, and the newness of the therapy does not alter this motivation. In non-therapeutic research, the doctor will have had to consider most seriously his or her own estimate of the risks and benefits, as well as that of the relevant Research Ethical Committee. Why, then, is there the considerable emphasis on disclosure of information, and the suggestion that consent should be based on the fullest information and preferably in writing? The likely explanation is that the doctor is here concerned about the rights of the patient, and understands that these rights can best be protected by information disclosure facilitating free and knowing choice.

This is, however, no less true in the standard medical act. The patient has rights there also, rights which are equally valuable and do not solely depend on the nature of the intervention. Indeed, it has been said by some that all medical acts are essentially experimental, since their outcome is seldom absolutely certain.[153] Concern for the patients' rights in standard medical practice would surely also demand the fullest possible disclosure. Moreover, to insist on, and to value, information disclosure in the experimental situation, defeats at least one of the arguments routinely used to limit information disclosure in the normal medical act.

As discussed above,[154] it is sometimes argued that disclosure is irrelevant or unnecessary because the patient is unlikely to understand the information. Thus, it is said, to insist on disclosure is merely wasteful of time and may be distressing to the patient. If this is to be a credible reason for non-disclosure, then it is not clear why doctors themselves regard disclosure as being significant in therapeutic experimentation, which very closely resembles the normal medical act. The only major difference in fact, is in the choice of therapy. Moreover, if the patient is unlikely to understand the information in the normal situation, on what basis can it seriously be considered that information, particularly in the non-therapeutic experimental situation will be more likely to be understood, and therefore that its provision is more valuable?

Thus, whilst non-therapeutic experimentation may represent a distinct category, even given that there may be a desire for knowledge also inherent in therapeutic experimentation, the accepted significance of consent provisions in the therapeutic experiment seems to be based on no more and no less a foundation than it should be in the standard medical transaction. In fact, it could even be argued that there is less, rather than more, to be gained from information disclosure in experimental situations, since standard risks can be made known to the patient where the therapy is well tried and tested, but in an experiment, by its nature, there may be unforeseen and unforeseeable consequences. The patient in the experimental situation is consenting blind in some cases and is potentially under great duress from the pressure of ill health, which may be so severe as to merit radical, innovative therapy. Information disclosure in other circumstances, however, can result in the patient being genuinely aware of known risks and benefits, and the information, therefore, may serve the purpose for which rules about consent were formulated.

## The Law and Experiments

Experiments may be therapeutic or non-therapeutic, and the regulation - if any - provided by the law will differ according to the type of innovation. The therapeutic experiment involves 'deviational, unpractised or unaccepted treatment',[155] in the interests of patient care. It seems more than likely that - outside the area of medical products - this represents the most common experimental encounter, and, of course, although scrutiny by the law is ultimately possible, '...the decision as to types of therapy and the responsibility for success or failure rest entirely with the clinician.'[156]

Choice of therapy is seen in most circumstances as being within the clinical competence or clinical freedom of the doctor. Thus, in Hatcher v. Black,[157] there was no criticism of the doctor for failing to disclose the alternative therapy which was available, even although a strict adherence to patients' rights would demand, not just disclosure of risks and benefits, but also disclosure of therapeutic options. The choice of therapy is seen as intimately linked to the exercise of the doctor's technical skills and, therefore, as primarily, if not totally, within his or her competence alone. Criticism of a choice of therapy which is experimental will be governed by the same rules which apply in reaching decisions about other aspects of the doctor's clinical role - namely, almost exclusively through the negligence action, and on the evidence of other professionals as to the reasonableness of the choice.

Thus, although patients' rights to 'personal integrity' or autonomy form the central theme of the ethical codes which concern themselves with experimentation, the law is more concerned with the reasonableness of the deviation from the norm than it is with the insult to the integrity of the individual.

The leading case in this area is the case of Hunter v. Hanley,[158] where the test for establishing liability in such cases was clearly enunciated. However, the law should, in the experimental situation as in the classic medical interaction, not merely be concerned with the technical aspect of the therapy. Doctors can be reassured by the rule in <u>Hunter</u> v. <u>Hanley</u>,[159] at least as far as the technical situation is concerned, but a further, and just as significant, aspect of the medical act must also be taken into account - that is the provision of information and the obtaining of consent.

If the doctor is to fulfil his or her obligation to respect the patient, and to meet the demands of the ethical code promulgated in the Declaration of Helsinki, then information must be given to the patient, and a <u>real</u> consent provided. The law's concern here will be the same as in all other medical situations. As Meyers says, where

> .... truly knowing and voluntary consent of the patient or subject has been obtained prior to any medical experimentation, the primary concern of the law has been satisfied and ..... the law should thereafter be concerned only with the method in which the experimentation is carried out and its effect and result ....[160]

In matters of therapeutic choice, therefore, respect for the patients's rights demands information as to the perceived risks and benefits, the fact that alternative therapy is available, and the doctor's reasons for opting for an innovative treatment. In this way, a knowledgeable consent can be offered or withheld.

However, it remains the case that most

experimentation is carried out in an effort to improve and refine clinical care. Thus, the doctor will normally only experiment when it is his or her view that standard therapy has failed and that the alternative has the potential to benefit the patient. Here, of course, lies the dilemma. Often innovative choice will only be considered where the situation in which the patient finds him or herself is very serious. Equally, however, whatever the motivation, the very nature of the enterprise renders it fundamentally difficult for real consent to be obtained, since not only will the risks and benefits possibly be unknown, but the patient may be under considerable pressure to accept the doctor's choice. If it is accepted that the negligence action is - at least given current decision-making - inherently flawed as device which can provide genuine scope for patients to redress grievances, then it will be equally flawed where the damage to the patient (emotional or physical) is the result of therapeutic experimentation.[161]

However, not all experimental encounters are of this sort. Non-therapeutic research - that is, experiments which seek knowledge for future use - overtly pose more moral problems, and yet represent a very real opportunity for clinical advance.

> Medical science relies on research and experimentation as do all other sciences, to advance its knowledge in man's fight against

> sickness and disease. Inevitably such experimentation must utilise human subjects if it is to have primary significance. For any new therapy, drug or treatment, there must always be the first patient or subject.[162]

In non-therapeutic experimentation, the role of the law is substantially to regulate experimentation with medical products. Decisions as to the morality of certain types of experiment will be made by Research Ethical Committees, but the doctor must fall back on the code of behaviour laid down by his own professional body and the the terms of the Declaration of Helsinki in most cases.

In its role as protector of individuals and their rights, the law must have concern both for the nature and quality of consent in experimentation and for the aims of the experiment. It has been said, for example, that:

> A philosophy of medicine is needed to help clarify medicine's goals in relationship to those of the technological civilisation. Medicine suffers from an abundance of means and a poverty of ends.[163]

Equally, it might be said, the law is slow to respond to the challenge presented by medicine. If medicine does 'suffer from a poverty of ends', then the public can only be adequately protected by a legal system which scrutinises practice carefully, and which reacts quickly and sensitively to protect the rights of the individual. The fact that the law's intervention in this area is minimal must be problematic. Whilst the medical profession has been sufficiently concerned to impose an additional layer of scrutiny to that of the clinical judgement of the instant doctor, this has not been adopted in law and therefore carries only professional sanctions. The patient who seeks redress in such situations will require to attempt this through the use of the negligence action, which has many drawbacks as a method for redressing grievances, both in general and in the specific example of medicine. How much more complex is the decision making process where experimental procedures are carried out?

When the Pearson Commission[164] considered this, it is worth noting that they made one of their rare recommendations for a change in the basis of liability. In the case of the volunteer for non-therapeutic experiments, the Commission recommended that liability should be on a strict basis, thus ending the practice of depending on ex gratia payments, and ensuring that the burden facing the damaged volunteer is considerably lightened.[165] A system based on strict liability would remove the need to prove fault, which can be extremely difficult for any aggrieved person, and which - it has been suggested - may be particularly difficult for the patient. Although causation, that is the link between the act and the subsequent damage, may remain a problem, there is no doubt that the burden on the pursuer would be less in a strict liability scheme. This recommendation was made in recognition of the service that volunteers for medical research do for the community.[166]

Having said this, even if it is accepted that real consent is impossible to achieve in experimental situations, the need to discuss what is known seems particularly urgent. The emphasis, however, on what other doctors would or would not have told the patient - an emphasis which runs through the negligence action[167] - makes it seems unlikely that the patient's rights will be adequately protected. The Declaration of Helsinki makes no mention of standard practice, and this is the code of ethics guiding both therapeutic and non-therapeutic experiments. What it is concerned with is the protection of the integrity of the individual - something which the law must also respect, one would have thought, as a matter of principle rather than as derivative from professional practice.

No less than in the standard medical act, the use of the negligence action in experimental situations permits of the importation of extra-legal factors into the decision whether or not the behaviour in question was, or was not, acceptable. Far from primary concern being shown for patients' rights, rather it is said that the search for knowledge and experience should not be inhibited by '...undue apprehension or charges of negligence for the consequences to a patient of treatment or diagnosis where such may diverge from the normal.'[168]

## Conclusions

It is clear from the above discussion that there are a number of difficulties attached to the negligence action in general - difficulties which relate in part to the attitudes of the courts, and in part to the nature of the action itself. Thus, the inclusion of the duty to disclose information in the doctor's general duty of care may prove to be the most problematic hurdle for the aggrieved patient. If is it the case, as Robertson suggests, that the development of the concept of informed consent by American courts was as much a device to expand the liability of the medical profession as it was anything else,[169] then even here it can be seen to have been, relatively speaking, a failure.

The extensive use of the professional test in the United States, as in the United Kingdom, makes successful challenge of non-disclosure unlikely, unless the failure to disclose was so great as to amount, in any event, to an assault, or to trespass against the person.[170] Even the development of other tests, such as the 'prudent patient' test, is not a complete answer. The nature of the proof required of the patient, and the rationalisation of behaviour inherent in the negligence action, remove the matter for consideration far from the individual aggrieved patient and render it subject to tests which are designed to be objective. However, as with all so-called objective tests, there remains the potential to incorporate policy, personal and professional prejudice and subjective assessments by courts and experts. That the finder of fact in the 'prudent patient' test is the court rather than the doctor, will be small comfort if it is borne in mind that courts have in the past demonstrated their own bias in favour of medicine as a 'good', and through this assessment have often deferred to doctors as a group and as individuals.

Of course, the use of an 'objective' test is an inevitable outcome of the use of the negligence-based action. This action is neither designed nor equipped to deal with purely subjective information, nor is it used other than to assess rationalised duties, and to decide on a reasonable basis what the duty is, and whether or not it has been breached. Even in those cases where there are clear statements to the effect that the law and not the medical profession sets the standard of care to be followed, there is little doubt as to the weight given to medical evidence.[171] Moreover, the use of therapeutic privilege, advocated even in the most radical judgements,[172] sufficiently reduces the impact of any theoretical attention to patient's rights as to render it merely rhetorical.

With the notable exception of the court in Canterbury v. Spence,[173] and the limited number of cases following it, emphasis in the United States has concentrated on 'informed consent' - a term much used even in cases in the United Kingdom. However, the use of this terminology can be misleading and gives rise to its own difficulties. What is really in issue is observance of the duty to disclose, which is a necessary precondition of real consent, and this duty can be separated from the question of 'informed' consent. For example, as will be shown below, a duty to disclose information may be thought to exist even in a situation where there is doubt as to the recipient's legal capacity to offer a real consent.[174]

That is, the duty arises independently of considerations such as clinical judgement, and is a clear and unequivocal vindication of the patient's rights. The negligence-based action is, it has been suggested, ill-equipped to deal with something as contentious and potentially abstract as the rights of the individual, where these are rights developed from morality, rather than stated in law or custom. Moreover, the structure of the action means that the decision inevitably reflects what <u>some</u> patient - the 'reasonable' patient - would have decided, and not what the instant patient would have done had information been shared. As a means of protecting individual freedoms, given that individuals are idiosyncratic, the negligence action cannot, as currently applied, be satisfactory.

Moreover, there is the fundamental difficulty that, not content with imposing one level of objectivity

- that is the 'reasonable doctor' test - courts are further willing to impose yet one more test - that of what information the 'reasonable patient' would have regarded as being of significance. Since apparently the individual's statement of what he or she would have found significant is not convincing,[175] the actual outcome is unlikely to be based on direct attention to individual rights. Indeed, given the nature of the negligence action, it is difficult to see how it could.

In any case, the noted reluctance of the judiciary in the United Kingdom to expand the liability of the medical profession[176] makes it less than likely that - even were significant change within the negligence framework possible - the position would be radically altered.[177] Whilst it is possible to argue with Robertson's plea for the use of the doctrine of 'informed consent' by British courts, for the reasons outlined above, the same remarks, if applied to a doctrine which concentrated on disclosure rather than on the subsequent offering of consent, would be valid. As Robertson says:

> It is submitted that the doctrine of informed consent is unikely to develop in this country and that consequently it will prove to be of limited scope in affording compensation to the victims of medical accidents. It is to be regretted that the law should seek to restrict the doctrine of informed consent in this way, since this belies the importance to be attached to the patient's fundamental right to decide whether to undergo proposed medical treatment. For this to happen, much less emphasis would have to be placed on concepts such as "accepted medical practice"

> and "best interests of the patient" as reasons for excusing non-disclosure. However, regardless of the importance of the patient's right in relation to the decision to undergo medical treatment, one cannot avoid the fact that the doctrine of informed consent, expanding as it does the liability of the medical profession, is the servant of judicial policy regarding such expansion. It is the judicial policy, rather than the importance of the patient's right to determine his own medical treatment, that will dictate the future development of the doctrine of informed consent in this country.[178]

Given the attitude to medical negligence described in an earlier chapter,[179] it seems even more unlikely at present that a move will be made in the United Kingdom to expand liability in this way. A situation has been reached whereby the judiciary, who themselves developed the negligence action, have also kept a tight control on its expansion. In medical cases, fear of extra-legal consequences such as the spread of defensive medicine, and consideration of extra-legal factors such as the good of medicine as a discipline and the impact of a finding of negligence on the doctor's position, are routinely used to deny liability. In the specific case of consent, the Bolam Test sets hurdles for the patient which, it is submitted, make it relatively certain that no claim will succeed unless the failure to disclose information is so gross as in any event to merit consideration under assault analysis.

If the question under examination is concerned with patients' rights, however, then the issue is not whether or not the patient would have rejected therapy, but whether or not the doctor is entitled to use the defence of volenti. For this to apply, the patient must have been informed of the type of risk(s) to which exposure was possible, and must have agreed to accept them. This is a test much more readily susceptible of proof, and in a sense much less objectionable, than that of reasonable or accepted medical practice. However, to consider the question from this perspective seems to be beyond the imagination of current decision-making practices in the United Kingdom or in the United States. Moreover, the sanctioning of the Bolam Test by the House of Lords[180] renders its application in the future even less likely.

It can be concluded, therefore, that as presently applied, the negligence action is unsuited to a vindication of patients' rights. Its lack of suitability is as much a matter of judicial attitude as it is an aspect of the nature of the action itself, although both contribute to the problems faced by the disaffected patient. The negligence action lacks the capacity for subjectivity which an adherence to individual rights would demand, and judicial fears and attitudes, however, well or ill-founded, serve merely to increase the distance between the claimant and possible damages. As Skegg notes:

> At present some English judges are likely to treat such evidence [of a common and approved practice] as conclusive, if the patient brings an action in which he challenges a doctor's failure to provide him with adequate information about a proposed procedure.[181]

One can only agree with him that it would be

> .....regrettable, if in future the English courts did not play a more important role in protecting the interests of patients who wish to be able to reach an informed decision about whether to consent to medical procedures...[182]

even if one does not necessarily agree that it would also be 'surprising'.[183]

One particular legal process has increasingly been claimed to be a more appropriate basis for attributing liability - avoiding the problems of the assault and the negligence based actions. This mechanism, it is claimed, could deal with the difficulties faced by patients and would avoid excessive judicial or medical impact on the assessment of the adequacy of information disclosure.

This would be a system of liability which did not depend on fault, and therefore did not require proof of the very factors which have been said to be particularly difficult for patients in traditional systems. There are, of course, a number of difficulties which centre on this innovative type of system, not least that some might argue that it is the attribution of personal fault which renders the claim for damages moral. Moreoever, it might be said, that a no-fault system provides little incentive to practitioners to consider the human rights involved in their practice since the state, and not they as individuals, will meet any award.

The most comprehensive no fault system in the world exists in New Zealand, and is worthy of careful consideration in order to assess its value a) as a scheme which routinely provides satisfactory compensation and b) as a system which generates or reinforces concern about human rights in sensitive and important interactions. The next section will consider its operation with particular interest in its effect on patients' rights to information disclosure in medicine.

NOTES

1. for discussion, see chapter 5, supra.
2. for discussion, see chapters 4 and 5, supra.
3. see chapter 4, supra.
4. c.f. Robertson, G., 'Informed Consent to Medical Treatment' 97 L.Q.R. 102 (1981)
5. loc.cit.
6. [1981] 1 All E.R. 257.
7. 'The Times' 2 July 1954.
8. [1957] 2 All E.R. 118.
9. loc.cit., at p. 114: 'Although it is clear that,

in order to obtain a valid consent from his patient, a doctor is required to explain the "nature and purpose" of proposed treatment, until recently it was not clear whether the doctor is also under a legal duty (independent of the *validity* of the patient's consent) to inform him of the risks inherent in the treatment, i.e. a duty corresponding to the doctrine of informed consent....'

10. Cmnd 7054/1978.

11. para 1315

12. Klass, A., *There's Gold in Them Thar Pills*, Harmondsworth, Penguin, 1975.

13. see, pp248-71 *supra.*

14. *Hills* v. *Potter* [1983] 3 All E.R. 716.

15. Although Scots and English law differ, the likelihood is that the Scottish courts would be equally likely to eschew the transatlantic doctrine of 'informed consent', in particular since it has developed in a common law system.

16. *loc.cit.*, at pp. 112-113; *Cull* v. *Butler* [1932] 1 B.M.J. 1195; *Hamilton* v. *Birmingham R.H.B.* [1969] 2 B.M.J. 456; *Chadwick* v. *Parsons* [1971] 2 Lloyd's Rep. 49 (Q.B.), [1971] 2 Lloyd's Rep. 322 (C.A.)

17. for discussion, see pp221-44 *supra.*

18. for discussion, see pp221-44 *supra*.

19. [1944] 1 K.B. 476.

20. at p. 479.

21. supra cit.

22. supra cit.

23. Buchanan, A., 'Medical Paternalism' 7 Philosophy and Public Affairs, 340 (1978).

24. supra cit.

25. 1955 S.C. 200

26. Robertson, loc.cit., at p. 115.

27. c.f. Rogers, W.V.H., Winfield and Jolowicz on Tort, (12th. Ed.), London, Sweet and Maxwell, 1984, at pp. 1-2: 'At a very general level, however, we may say that tort is concerned with the allocation or prevention of losses, which are bound to occur in our society. It is obvious that in any society of people living together numerous conflicts of interest will arise and that the actions of one man or group of men will from time to time cause or threaten damage to others.'; Walker, D.M., The Law of Delict in Scotland, (2nd. Ed., revised), Edinburgh, W. Green & Son Ltd., 1981, at pp. 8-9: 'The social function of the law of delict is to give legal recognition and protection to certain valuable interests of the individual and of groups of individuals and corporate persons.'

28. c.f. Paris v. Stepney Borough Council [1951] A.C. 367; General Cleaning Contractors v. Christmas [1952] 2 All E.R. 1116; Barkway v. South Wales

Transport [1950] 1 All E.R. 402; Lloyd's Bank v. E.B. Savory & Co. [1933] A.C. 233; Hunter v. Hanley, supra cit.; Markland v. Manchester Corporation [1934] 1 K.B. 566.

29. supra cit.

30. 'The Times' 6 November 1981; for further discussion of this case, see chapter 8, infra.

31. Note the equivalence of this to a form of euthanasia, which remains murder; for further discussion, see Mason, J.K. and McCall Smith, R.A., Law and Medical Ethics, (2nd Ed.), London, Butterworths, 1987, chapter 7. For the legality of euthanasia, see Williams, G., Textbook of Criminal Law, (2nd Ed.), London, Stevens & Son Ltd., 1983; Gordon, G.H., The Criminal Law of Scotland, (2nd Ed.), Edinburgh, W. Green & Son Ltd., 1978.

32. supra cit.

33. c.f. Montrose, J.L., 'Is Negligence an Ethical or a Sociological Concept?' (1958) 21 M.L.R. 259, discussing the judgement of McNair, J., in Bolam supra cit., at p. 261: 'From the premises of McNair, J. it does indeed follow that in "a situation which involves the use of some special skill or competence", and where there are diverse practices followed by those possessed of that skill, then conformity with one of those practices cannot be negligent.'

34. see chapter 4, supra.

35. c.f. Sidaway v. Board of Governors, Bethlem Royal Hospital [1985] A.C. 871, [1985] 1 All E.R. 643 (H.L.); Hills v. Potter, supra cit. For a criticism of the professional standard test, see Robertson, loc.cit.; see also, Howie, R.B.M., 'The Standard of Care in Medical Negligence' (1983) Juridical Review 193; McLean, S.A.M., 'The Right to Consent to Medical Treatment' in Campbell, et al., (eds), Human Rights: From Rhetoric to Reality, Oxford, Basil Blackwell, 1986; McLean, S.A.M., 'Negligence - a Dagger at the Doctor's Back?', in Robson, P., and Wathcman, P. (eds), Justice, Lord Denning and the Constitution, Aldershot, Gower, 1981; Robertson, G., 'Whitehouse v. Jordan - Medical Negligence Retired' [1981] 44 M.L.R. 457; Winfield and Jolowicz on Tort, supra cit., at p. 102: 'Failure to conform with general practice may raise an inference of negligence against the defendant and it has been held at first instance that it reverses the burden of proof and requires the defendant to justify his conduct. However, it is certain that a showing of conformity with general and approved practice will generally lead to a decision for the defendant.'

36. [1984] 2 All E.R. 513, [1986] 1 All E.R. 497 (C.A.)

37. [1986] 1 All E.R. 497, at pp. 506-507.

38. _supra cit._, at p. 1028, where he said that a practice must be '..._rightly_ accepted as proper...'

39. Even here, however, Lord Scarman pointed out, at p. 654, that even so: 'The "prudent patient" test still calls for medical evidence.'

40. for discussion, see chapter 4, _supra._

41. _supra cit._

42. _supra cit._

43. _supra cit._

44. _supra cit._

45. at p. 266

46. see chapter 5, _supra._

47. _loc.cit._, at p. 117.

48. e.g. _Sidaway_, _supra cit._; _Eyre_ v. _Measday_ [1986] 1 All E.R. 488; _Lee_ v. _South West Thames R.H.A._ (1985) _N.L.J._ 438; _Gold_ v. _Harringey Health Authority_ 'The Times' 17 June 1986.

49. Robertson, _loc.cit._, at p. 117.

50. _supra cit._

51. 464 F 2d. 772 (1972).

52. _supra cit._, at p. 512.

53. _supra cit._

54. at p. 511.

55. per Nourse, J., at p. 511.

56. _id._

57. _supra cit._

58. _loc.cit._

59. at p. 122

60. *supra cit.*

61. see *Sidaway*, *supra cit.*, (C.A.)

62. *supra cit.*; for further discussion of this test, see chapter 5, *supra.*

63. e.g. *Blyth* v. *Bloomsbury A.H.A.* 'The Times' 24 May 1985 - but here the decision was based on the fact that the treatment (sterilisation) was carried out for convenience rather than on 'therapeutic' grounds; *Gold* v. *Harringey*, *supra cit.*

64. Brazier, M., *Medicine, Patients and the Law*, Harmondsworth, Penguin Books, 1987.

65. at p. 63.

66. see pp 336-41 *infra.*

67. see chapter 8, *infra.*

68. at p. 656

69. This is clearly in line with the *Bolam* test described *supra.*; for further discussion, see chapter 5, *supra.*

70. at p. 656

71. at p. 657

72. *supra cit.*

73. at p. 658

74. at p. 659

75. *supra cit.*

76. at p. 217.

77. *supra cit.*

78. at pp. 660-661

79. (1980) 114 D.L.R. (3d) 1.

80. at p. 13.

81. at pp. 662-663.

82. for discussion, see chapter 5, _supra._

83. at p. 665

84. c.f. Brazier, M., 'Informed Consent to Surgery' _19 Med. Sci. Law_ 49 (1979).

85. at p. 666: 'The duty of the doctor....subject to his overriding duty to have regard to the best interests of the patient, is to provide the patient with information which will enable the patient to make a balanced judgment if the patient chooses to make a balanced judgment.'

86. _id._

87. for further discussion, see chapter 5, _supra._

88. at p. 649

89. at p. 650

90. at p. 651

91. at p. 652

92. at p. 653

93. at p. 654

94. _id._

95. _supra cit._

96. id.

97. _supra cit._

98. Although Brazier, _op.cit._, maintains that this is not the end of the debate, it is submitted that, given the narrowness of the distinction between the prudent doctor and the prudent patient tests,

and the dependence on the professional test for the purposes of this approach to consent, the debate is substantially, if not definitively, over.

99. <u>supra cit.</u>

100. for discussion, see chapters 1 and 2, <u>supra.</u>

101. <u>supra cit.</u>

102. <u>supra cit.</u>

103. <u>loc.cit.</u>, at p. 122.

104. for discussion, see <u>Winfield and Jolowicz on Tort</u>, <u>supra cit.</u>; <u>Street on Torts</u>, (7th. Ed.), London, Butterworths, 1983; as Walker, <u>op.cit.</u>, says at p. 9: 'It does not necessarily follow from the assertion of some right as a natural right or a human right, or as an individual or social interest, that the law will protect it and enforce legal rights and duties arising therefrom. Whether or not to recognise some interest is a policy decision for the law...'

105. <u>op.cit.</u>

106. at p. 7; see <u>Ross</u> v. <u>Caunters</u> [1980] Ch. 297; <u>Junior Books Ltd.</u> v. <u>Veitchi Co.</u> [1982] 3 W.L.R. 477.

107. <u>op.cit.</u>, at p. 43.

108. see also, Walker, <u>op.cit.</u>, at p. 489: 'The claim for damages [in assault] is not merely for damage sustained, but <u>in solatium</u> for affront and insult, and it is not discharged by the application of criminal sanctions. Hence solatium can be

claimed even where no actual injury is or can be proved.'

109. supra cit.

110. supra cit.

111. supra cit.; but see Skegg, P.D.G., Law, Ethics and Medicine, Oxford, O.U.P., 1984, at p. 83: '...by no means all decisions taken by doctors concern matters within the extensive competence of the medical profession, and with these matters the courts should not act as if evidence of any common and approved practice was determinative.'

112. supra cit.

113. supra cit.

114. 'The Times' 24 May 1985.

115. id.

116. supra cit.; the court said (n. 36) 'We discard the thought that the patient should ask for information before the physician is required to disclose. Caveat emptor is not the norm for the consumer of medical services. Duty to disclose is more than a call to speak merely on the patient's request, or merely to answer the patient's questions; it is a duty to volunteer, if necessary, the information the patient needs for intelligent decision.'; but see also the Canadian case of Lepp v. Hopp (1979) 98 D.L.R. (3d) 464, at p. 470: 'In my view, the law draws a distinction between the general duty of disclosure

imposed upon a surgeon when he is obtaining a patient's consent to surgery and the duty of disclosure he is under when he responds to specific questions from his patient...When specific questions are directed to the surgeon he must make a full and fair disclosure in response to them.'; see also, Hatcher v. Black, supra cit.

117. supra cit.

118. supra cit.

119. at p. 124

120. at p. 659

121. at p. 664

122. (1975) 1 B.M.J. 635.

123. supra cit.

124. supra cit.

125. at p. 470.

126. loc.cit., at pp.118-120.

127. [1965] N.Z.L.R. 191.

128. [1964] A.C. 465.

129. Robertson, loc.cit., at p. 119.

130. at p. 120.

131. supra cit.

132. n. 36.

133. further discussion can be found in Katz, B.F., Experimentation with Human Beings, New York, Russell Sage Foundation, 1972; Annas, G.J., Glantz, L.H. and Katz, B.F., Informed Consent to Human Experimentation: The Subject's Dilemma,

Cambridge, Mass., Ballinger Publishing Co., 1977; Meyers, D., The Human Body and the Law, Edinburgh, E.U.P. 1970; Mason and McCall Smith, op.cit., chapters 16 and 17; Brazier, op.cit., chapter 18; Belsey, A., 'Patients, Doctors and Experimentation: Doubts About the Declaration of Helsinki' (1978) 4 J. Med. Ethics 182; Soutar, D.S. and McLean, S.A.M., 'Medical Progress and the Law', in McLean, op.cit.; Rudowski, W., 'World Health Organisation Biomedical Research Guidelines and the Conduct of Criminal Trials' (1980) 6 J. Med. Ethics 58.

134. revised in 1975; for discussion of clinical trials, see Responsibility in Investigations on Human Subjects, Report of the Medical Research Council of 1962-63, Cmnd 2382; 'Informed Consent: ethical, legal and medical implications for doctors and patients who participate in randomised clinical trials' 286 B.M.J. 1117 (1983)

135. II, para 1.

136. II, para 2.

137. III, para 3a); see also Halushka v. University of Saskatchewan (1966) 53 D.L.R. (2d) 436.

138. III, para 4a)

139. for discussion, see chapter 2, supra.

140. Klass, op.cit., at p.31: '...human medical experimentation must continue, or progress in drug treatment will cease.'; see also Dickens, B.,

'What is a Medical Experiment?' 113 Can. Med. Ass. J. 635; for discussion, see Lomasky, L.E., 'Medical Progress and National Health Care' 10 Philosophy and Public Affairs (1981); Meyers, op.cit.; R.C.P.S. (Glasgow) 'Concerning Responsibility in Research Investigations on Human Subjects' May 1972.

141. c.f. Klass, op.cit., at p. 31: 'This is the kind of experimentation that must inevitably take pace when the first, the very first, course of treatment with a new drug is carried out on a human, or the first surgical operation promising an improvement over the previous one is attempted.'

142. leading to the Nürnberg Code; for discussion, see Mason and McCall Smith, op.cit., chapter 16.

143. through the voluntary establishing of Research Ethical Committees on the publication of 'Responsibility in Investigations on Human Subjects' B.M.J. 177 (1963); see also B.M.A. statement in 282 B.M.J., 21 March 1981; Royal College of Physicians of London (1967, 1973), Report of Committee on the Supervision of the Ethics of Clinical Investigations in Institutions; S.H.H.D. (1972) Memorandum on the Supervision of the Ethics of Clinical Research Investigations, 30/1972.

144. for example, proxy consent is permitted in therapeutic research by II, para 1, and in

non-therapeutic research by III, para 3a)

145. see chapter 1, supra.

146. for further discussion, see Mason and McCall Smith, op.cit.; Soutar and McLean, loc.cit.

147. c.f. Thompson, I.E., et al., 'Research Ethical Committees in Scotland' B.M.J. 718 (1981).

148. see B.M.A. statement, n. 143, supra.

149. e.g. Hunter v. Hanley, supra cit.

150. Medicines Act 1968; Medicines (Commission on Safety of Medicines) Order 1970 SI 1970/1257.

151. see n. 150, supra.

152. see, e.g. Thomson, loc.cit., at p. 719: 'There is considerable and confusing lack of uniformity in arrangements for the different types of ethical committees. Even at the same level they vary dramatically in size, composition, remit and mode of operation. Some serve as little more than debating forums, while others seek to maintain quite strict supervision on research.' As an additional check, a drug surveillance unit was set up at Southampton University - see 'Times Higher Education Supplement' 23 January 1981.

153. Meyers, op.cit., at p. 72: 'Under a broad definition, recognised medical treatment might be classified as experimental owing to the peculiarity presented by any given patient's case.'

154. see, for example, chapter 2, supra.

155. Meyers, op.cit., at p. 73.

156. Soutar and McLean, loc.cit., at p. 123.

157. supra cit.

158. supra cit.

159. supra cit.

160. Meyers, op.cit., at p. 76.

161. In any event, as Lord Denning said in Roe v. Ministry of Health, supra cit., at p. 83: 'Every advance in technique is attended by risk. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way.'

162. Meyers, op.cit., at p. 70.

163. Pellegrino, E., and Thomasma, D., A Philosophical Basis of Medical Practice, Oxford, O.U.P., 1981, at p. vii.

164. Cmnd 7054/1978.

165. That is, the claimant would have to show causation but not fault.

166. para 1341: 'We think that it is wrong that a person who exposes himself to some medical risk in the interests of the community should have to rely on *ex gratia* compensation in the event of injury. We recommend that any volunteer for medical research or clinical trials who suffers severe damage as a result should have a cause of action, on the basis of strict liability, against the authority to whom he has consented to make himself available.'

167. see chapter 5, supra.

168. McHardy v. Dundee Hospitals 1960 S.L.T. (Notes) 19, at p. 19

169. loc.cit., at p. 109.

170. for discussion, see chapter 3, supra.

171. see chapter 4, supra.

172. e.g. Canterbury v. Spence, supra cit.; see also the judgement of Lord Scarman in Sidaway, supra cit.

173. supra cit.

174. see chapter 8, infra.

175. c.f. Cobbs v. Grant 104 Cal Rptr. 505 (1972) 'Subjectively he may believe [that he would have declined treatment] with the 20-20 vision of hindsight but we doubt that justice will be served by placing the physician in jeopardy of the patient's bitterness and disillusionment.'; see also, McNorrie, K., 'Informed Consent and the Duty of Care' 1985 S.L.T. 289; Mason and McCall Smith, op.cit., at p. 151: 'The obvious difficulty....is one of discounting the wisdom of hindsight. It will be only too easy for a plaintiff, once he has suffered damage, to allege that he would not have given his consent to the procedure, when, in reality, he may well have been prepared to do so, even with full knowledge of the risks entailed....'

176. see chapter 4, supra.

177. for further discussion, see chapter 9, infra.

178. _loc.cit._, at p. 126.

179. see chapter 4, _supra._

180. _Sidaway_, _supra cit._

181. _op.cit._, at p. 86.

182. _id._

183. _id._

# Chapter 7

In most legal systems throughout the world, liability for damage caused is attributed on a personal basis, primarily through the law of tort/delict. Although liability may arise in some cases through other systems, such as strict liability schemes, the standard legal mechanism for obtaining compensation is through the use of a civil action maintaining corporate or individual fault. The tort or delict of negligence is a relative newcomer to the panoply of available actions,[1] but it is perhaps the one which has attracted the most comment and criticism.

However the fault based action also has a number of attractions in that it is claimed to serve purposes which are cherished by the law. It is seen by some as having a deterrent effect, demonstrating the unpleasant and potentially expensive consequences of certain types of behaviour.[2] It is also in theory an action which brings home to the tortfeasor his or her own behaviour and thereby renders him or her personally accountable to make good the harm complained of. Nonetheless it also has many critics who see it as a costly, protracted and ultimately unpredictable method of compensating victims. Further, political and economic considerations may render its inherent dependence on the personal attribution of fault and the individual payment of compensation, distasteful.

In recent years, there has been an upsurge of public interest in, and concern about, victims in society. Whilst this concern has often concentrated on relatively specific groups - such as the victims of crime[3] - there would seem nonetheless to be a generalised perception that victims are inadequately dealt with by the existing legal processes. In New Zealand, it was partly this concern which generated the impetus for the creation of the world's most far-reaching and comprehensive alternative system of liability - the accident compensation scheme. In 1972, following the recommendations of the Report of the Committee of Inquiry into Personal Injury in New Zealand (Woodhouse Report),[4] the New Zealand legislators passed the Accident Compensation Act - subsequently amended a number of times, culminating in the Accident Compensation Act 1982 which is designed as consolidating legislation. The crucial and most interesting features of this scheme, which has its fair share of advocates and critics, are that eligibility is based on tests which exclude the need to prove fault, and that payment of compensation is made by the state and not by the individual. This chapter will trace the development of the scheme and discuss some of the benefits and drawbacks of compensation without fault, with particular reference to its effects in the doctor/patient relationship.

## The Woodhouse Report

New Zealand has a fine history of social legislation, having adopted one of the world's earliest forms of welfare state. It is a small and relatively close community in which the idea of community involvement in the welfare of citizens is both respected and meaningful. In some ways, therefore, it may be seen as the ideal community for the type of scheme proposed by Woodhouse, which depends heavily on the community accepting a particular view of a benevolent state to which all citizens contribute, and from which all have equal entitlement for help. Indeed, there is little doubt that the Woodhouse proposals were as much a reflection of a political view as they were of a purely legal reform.

The Commission was, in fact, given a very narrow remit within which to consider what alternatives, if any, there might be to the existing systems of liability. The terms of the remit were to:-

> '...inquire into, investigate, and report on the following matters:
> 1. Any need for change in the law relating to claims for compensation or damages in respect of persons incapacitated or killed in employment.
> 2. The institution and administration of a scheme for the payment of compensation or damages, in whole or in part, by periodic payments, in respect of persons incapacitated or

killed in employment.[5]

The aim of the government then was fundamentally to establish what could be described as a superior system of compensation for the work force - presumably in view of the economic impact of injuries at work - rather than to establish a wholesale alternative scheme of liability for all. Woodhouse, however, chose to interpret his remit in a far wider way and succeeded thereby in including <u>all</u> citizens within his recommendations. All members of the community were viewed by Woodhouse as past, present or potential workers or, as in the case of housewives, as people whose support was essential for the continuation of a healthy work force.[6] By this essentially political sleight of hand, no-one was to be excluded from the operation of the new scheme merely by reason of their status or actual financial contribution to the state.

There were two main thrusts to the Woodhouse recommendations, both of which can be described as essentially political. The first depends on an economic assessment of worth. The maintenance of a viable work force was seen as essential to the economic well-being of the state and special facilities could therefore be justified for maintaining their health and welfare. As the Report says:

> If the well-being of the work force is neglected, the economy must suffer injury. For this reason the nation has not merely a clear duty but also a vested interest in urging

> forward the physical and economic rehabilitation of every adult citizen whose activities bear on the general welfare.[7]

The welfare of the individual, in these terms, becomes vital substantially because it contributes to the welfare of the state.

However, perhaps the more important aspect of the Woodhouse Report was its political view of the role of state (and by definition each individual member of the state) in assuring the physical well-being of all citizens. It is this commitment to community involvement and responsibility which, it is submitted, actually predicted the type of scheme which Woodhouse was to recommend. The inevitable interest of the state in the well-being of citizens is more, in the view of the Report, than merely an economic one. It is also a moral commitment which demands the involvement of all in the welfare of all. Thus, the logical paymaster in the new scheme becomes government rather than the individual. In the Woodhouse view, all citizens are potential victims of society's need and demand for progress. As the Report puts it:

> The toll of personal injury is one of the disastrous incidents of social progress, and the statistically inevitable victims are entitled to receive a co-ordinated response from the nation as a whole.[8]

As a political philosophy this becomes a convincing argument for community responsibility which is, nonetheless, dependent on the nature of the actual state to which it is applied. Under certain political regimes, the emphasis on state as the benefactor and guardian of all would be unacceptable. The blame for harm inherent in such a view would be eschewed by some who would prefer to view damage, in many cases at least, solely as being the 'statistically inevitable' outcome of personal misbehaviour rather than as representing the results of a communal acceptance of risk in the interests of advancement.

However, whether or not it is actually society's demands for progress which create risk, the Woodhouse view has found acceptance by a number of commentators. As Gaskins, Kronick and Vosburgh put it:

> ...society as a whole should pay the cost of progress as well as reap the benefits. Justice demands that principles of equity be invoked to determine the standard of payment; what an individual actually loses when a community adopts a given way of life should be restored by the community. Such restoration is the right of the individual by virtue of being a victim, and no further test of eligibility should be required. Such rights exist for all on a universal basis.[9]

Such then is the philosophy to which Woodhouse adhered, and regardless of whether or not it is politically acceptable to all, it nonetheless contains the potential for the creation of a comprehensive and accessible system of compensation. However - and vitally for the New Zealand scheme - compensation in these terms need not be merely financial. It is a known, but apparently unavoidable, implication of the fault based system that its remedies remain almost exclusively financial.[10] The involvement of the state as direct controller of the system of redress in New Zealand provides the potential for all the resources of that state to be involved in the process. Rehabilitation, then, is a plausible concommitant of such a scheme, and satisfies both of the main thrusts of the Report itself. Restoration, or maintenance by accident prevention, of a healthy work force may be achieved in part by the replacement of individual financial loss, but may also be facilitated by the availability of retraining and other related schemes. Accident prevention, through the systematic collection of relevant data, and by the imposition of sanctions on, for example, companies with a bad safety record, become not merely possible adjuncts to a system of liability but rather an integral part of it.

Financial compensation, whilst important, becomes in some ways the tail end of a state organised and funded process rather than the rationale for the whole scheme. The system in theory is designed as much to avoid injury to individuals as it is to ensure mitigation of any loss which does arise. In order to achieve these aims however, substantial changes were necessary in the existing legal, and perhaps even political, establishment. Surprisingly perhaps, the Woodhouse recommendations which made such changes seem morally inevitable neither arose out of major public discontent nor resulted in the type of fierce debate which might have been anticipated. As Palmer notes, '[p]erhaps the most surprising conclusion to emerge from the New Zealand experience is that, although the proposed reform was massive, it never became a major political issue.'[11] No powerful interest group made the failures of the pre-existing system of liability a rallying cry, unlike many other legal reforms which have been generated by public discontent, and few interest groups seriously disputed the wisdom of the changes proposed.

Certainly, the Report itself reads convincingly and those in political agreement with its aims would find its recommendations hard to dispute. Equally, it is reassuring about the costs of the scheme - a reassurance which may have played a significant part in the absence of overt hostility to its recommendations. Having set a clear philosophical tone, Woodhouse was then free to turn his attention to the pre-existing legal structure, to expose its problems and to make practical suggestions for improvement. It was, of course, vital to the acceptability of the new scheme that the old one was thoroughly discredited, and the Report spares no effort doing so. In the view of the Commission there are four main criticisms of the common law action:

> They describe the philcsphy on which it depends as illogical, the verdicts as entirely uncertain and affected by mere chance, the procedure as

> costly and slow moving, and the nature of the award and the whole process as an impediment to rehabilitation.[12]

Fault is declared to be a 'legal fiction'[13] in the sense that its force in evidencing a moral attribution of responsibility is now dissipated, and that, in view of the number of alternative processes of decision-making which actually operate in most developed communities, it no longer satisfies any practical purpose in such an attribution. Rather, according to the Report:

> The moral basis for the application of the fault principle cannot be explained in terms of the legal conception of negligence because the test of negligence is objective and impersonal.....Nobody can predict with any assurance the outcome of a damages action.[14]

The fault based action according to the Woodhouse Report and indeed to many other of its critics, requires too much of the victim. Litigation is expensive and protracted and the outcome uncertain. By its nature, it is argued, it not only fails to bring home to the wrongdoer personal accountability for his or her actions or omissions, but it also leaves many people uncompensated. The difficulties of proving fault mean that those who 'either lack the proof of fault or who are the victims of what lawyers pleasantly call "an act of God"'[15] are left without redress. The use of the negligence action as a means of securing the welfare of the work force was therefore seen as relatively ineffective, and as a means of satisfying the responsibility of the community, absolutely useless. It is, to the Commission, self-evident that this is a random and perhaps even distasteful basis on which to obtain justice for the victims of modern society. As the Report says:

> The fact should be faced that despite the moralising which has enabled the fault theory to develop it is really not possible to equate negligence as an independent tort with moral blameworthiness. Negligence is tested not in terms of the state of mind or attitude of the actual defendant, but impersonally against the (occasionally remarkable) performance of a theoretical individual described as the "reasonable man of ordinary prudence".[16]

By its very nature the negligence action could never achieve the aims of the Woodhouse Commission - of course it was not designed to do so. Its emphasis on personal responsibility, its expense and uncertainties could never provide assistance for all those who might need it. Nor, as has already been noted, is there any necessary element of rehabilitation in this type of action. All in all, one of the major sources of restitution is systematically dismissed as unsatisfactory by the Report.

Apart from the technical legal changes introduced by the new scheme, it was also instrumental in 'allowing what had been a private dispute between individuals in the legal system to become a problem in public law involving welfare issues'.[17] Through this scheme the community assumes the mantle of protection for the individual by using its resources to prevent loss and compensate injury. Although the system is contributed to by individuals through, for example, a form of road tax, it is the state which bears the major burden. This is seen as serving the interests of both state and individual.

However convincingly Woodhouse attacks the negligence action, commentators have noted that his attack can be criticised methodologically. Unlike the Royal Commission on Civil Liability and Compensation for Personal Injury (Pearson Commission)[18] in the United Kingdom, it is argued by some that scant attention was paid by Woodhouse to an actual detailed analysis of the success or failure of cases taken under the common law.[19] Equally, as Palmer points out:

> There are serious methodological reasons for doubting that a survey of cases filed in court can adequately reflect the performance of a system in which almost all cases are settled with no proceedings being filed in court.[20]

Woodhouse was not, however, so naïve as to fail entirely to take account of these points. Indeed, in the view of the Commission, the fact that so many cases were settled out of court was in itself a kind of indictment on the common law action. It was felt that such settlements often merely reflected the unwillingness of the people concerned to risk the vagaries of the common law action. Any settlement may be better than no award at all. In any event, it may be that the only cases in which the rules of the fault based action are strictly adhered to are those cases which end up in a court of law. Other factors may also influence the making of out of court settlements,[21] and in some ways therefore, there is a certain sense in using the court cases as at least an indication of the limitations of this system of obtaining redress.

Despite such methodological criticisms, few would argue that the fault based system is ideal. Even the strongest defenders of tort or delict have been critical of some of its manifestations, and its death knell was surely sounded in New Zealand when the Woodhouse Commission reported. The attack made by the Woodhouse Report on the negligence action is powerful and convincing - as indeed it had to be. As Palmer noted,[22] anything less than 'a compelling case against the common law' might have left room for compromise solutions which would affect both eligibility for compensation and the financial underpinnings of the new scheme which broadly sought to appropriate available funds to itself. The case, therefore, had to be 'utterly devastating'[23] and in view of the adoption of the Woodhouse proposals, one assumes that it was indeed convincing.

With the apparent support - or at least without the overt hostility - of the community in New Zealand, the Woodhouse proposals substantially unamended became law with the passing of the Accident Compensation Act 1972. The scheme commenced operation in 1974, and the legislation subsequently required a number of amendments, culminating in the consolidating legislation of 1982.[24] The amendments to the legislation were reflections of the, perhaps inevitable, teething problems of the scheme, and were by and large designed as a means of including, rather than excluding, certain groups in the community, and of clarifying terminology.

The legislation set up the basic structure of the system and outlined the basis for eligibility. The mere fact that eligibility had to be described points instantly to one of the problems of the system. The Woodhouse Report, despite its radical political and economic vision, itself demonstrated what might be seen as inconsistencies which were translated into the legislation. Eligibility is based on damage resulting from 'personal injury by accident' which is defined as follows:

'"Personal injury by accident" -

(a) Includes -

(i) The physical and mental consequences of any such injury or of the accident:

(ii) Medical, surgical, dental, or first aid misadventure:

(iii) Incapacity resulting from occupational disease or

industrial deafness to the extent that cover extends in respct of the disease or industrial deafness...

(iv) Actual bodily harm (including pregnancy and mental or nervous shock) arising by any act or omission of any other person which is within the description of any of the offence specified in sections 128, 132, and 201 of the Crimes Act 1961, irrespective of whether or not any person is charged with the offence and notwithstanding that the offender was legally incapable of forming a criminal intent:

(b) Except as provided in the last preceding paragraph, does not include -

(i) Damage to the body or mind caused by a cardio-vascular or cerebro-vascular episode unless the episode is the result of effort, strain, or stress that is abnormal, excessive, or unusual for the person suffering it, and the effort, strain, or stress arises out of and in the course of the employment of that person:

(ii) Damage to the body or mind caused exclusively by disease, infection, or the ageing process'[25]

The exclusion of disease from the definition of personal injury by accident reflects the views of the Woodhouse Commission itself[26] and has proved to be problematic for some of those seeking to obtain redress for harm. Indeed, in view of the expressed commitment of the Woodhouse Report to maintaining a healthy and effective work force, it is difficult to justify this exclusion on any grounds other than the purely economic. The person who is sick is no less disabled from fulfilling his or her role in the community. Equally, although the welfare state makes provisions for the sick these same provisions also apply to the injured and cannot therefore provide a reason for the differentiation. In any event, the Woodhouse Report itself made the statement that 'all injured persons should receive compensation from any community financed scheme on the same uniform method of assessment, regardless of the causes which give rise to their injuries.'[27]

The vision of Woodhouse seems considerably modified by this exclusion, and in fact it is worth noting that when Mr. Justice Woodhouse subsequently chaired a similar Commission in Australia,[28] no such distinction was made - a recognition perhaps of the toll of personal suffering and community losses which can be occasioned by the making of such an intricate and discriminatory distinction.

At first sight, however, the definition of personal injury by accident - even whilst containing this inconsistency - seems a relatively straightforward basis on which to assess eligibility. Unfortunately this has not always proved to be the case, and indeed Cripps has claimed that:

> The meaning of 'accident' for the purposes of the Act has been a fundamental problem which has not been simplified by legislative definition. However, it is clear that merely because an injury is unexpected and caused by negligence it will not necessarily be covered by the Act.[29]

As with most permissive legislation, and in particular where the central definition is relatively vague, interpretation may serve to limit or expand eligibility. In some ways it would seem that the decision-makers in the accident compensation scheme have adopted a restrictive rather than a liberal interpretation of what amounts to 'accident' and have thereby limited the availability of cover under the scheme.[30] Palmer suggests that:

> To begin with the idea was to spell everything out so people would know their rights. The trend of the amendments has been to give more and more discretion to the Commission so that certainty is lost but the obscurity remains. At present neither clarity nor predictability exist.[31]

It is ironic that this is one of the criticisms also often levelled at the common law action.

The interpretation of 'accident' was intially based on the definition contained in the British case of <u>Jones</u>

v. Secretary of State for Social Services[32] and related to an unlooked-for or undesigned event. Despite the Accident Compensation Corporation's advice to the medical profession that "[a]s a matter of general principle personal injury by accident means any form of damage to the human system which is unexpected and which was not designed by the person injured'[33] such apparent clarity merely disguises actual interpretational variations. For example, in one case[34] it was said that, '[a]ccident should be interpreted in its ordinary and popular meaning, as normally denoting an unlooked-for mishap or untoward event which is neither expected nor designed', and one moreover which is 'capable of being described as occurring at some particular time rather than by gradual process'. However in yet another relatively contemporaneous case it was said that:

> If a happening is accidental merely because it is a happening by chance then I suppose it must be conceded that the happening is an accident but only to the extent that it is a chance. The daily life of every one of us is packed with chance happenings, fortuitous occurrences, coincidences, etc. of every conceivable kind. All these may be claimed by the pedants or grammarians as 'accidents' in that they occur otherwise that by design. Each is in fact a chance happening and I cannot conceive that in selecting 'accident' as the basic criterion for the operation of the Accident Compensation Act the legislature intended that the word embrace all chance happenings. I would regard the argument that as virtually all accidents are chance happenings therefore all the chance happenings of everyday life are accidents as fallacious.[35]

One must ask why, in view of the rationale for the accident compensation scheme, such an argument should be deemed to be fallacious? Unlike its predecessor, the no fault system purports to be concerned with the <u>effects</u> of incidents rather than with their <u>causes</u>. It seeks, in theory at least, to include rather than to exclude. Indeed, if it is to be both philosophically sound and pragmatically effective it must provide the widest cover for the work force (as broadly defined by Woodhouse). If a narrow definition of accident is adopted some - perhaps many - will go uncompensated by the scheme, which will then find itself sharing at least that characteristic with the system it replaced.[36]

Moreover, concern may be reinforced if the scheme adopts an inflexible and narrow approach, since the effect of its introduction was to remove certain options from the potential litigant. Removal of sensitive and complex matters from courts of law (whilst not absolute) nonetheless is central to the system and may be its greatest strength or its greatest weakness. Which of these it turns out to be will depend substantially on the attitudes of decision-makers. Eligibility depends on evidence of 'personal injury by accident' which requires first, that there is an injury, and second that the injury resulted from this event which was in the nature of an accident. Morececver, the accident must result from an external cause and be an event, not a process. As Lord Diplock said in <u>Jones</u> v. <u>Secretary of State for</u>

> It cannot be the personal injury itself which is described as the cause. It must be something external which has some physiological or psychological effect on that part of the sufferer's anatomy which sustains the actual trauma, or some bodily activity of the sufferer which would be perceptible to an observer if one were present. It is convenient to call this external event or bodily activity the causative element.[38]

Moreover, and again this may be seen as a fundamental illogicality, the existence of the accident compensation scheme does not preclude the use of a residual common law action. Merely it precludes the use of this form of action where the injury complained of results from personal injury by accident. The retention of the common law action may be a surprise to some - surprising because its retention seems to suggest from the outset that there will be those, who have the necessary proof of injury, but who will nonetheless not be included in the scheme. Thus, the Woodhouse vision of a form of social insurance offering real, meaningful and readily accessible compensation, was ab initio acknowledged, in the cases of the sick and of some of those who are injured, not in fact to be comprehensive at all.

It may be inevitable that the decision-makers in a state funded scheme have an interest in limiting the availability of awards. Financial considerations will be likely to weigh heavily, even although - as in the case of the accident compensation scheme - there is evidence not of financial stringencies but rather of considerable reserves.[39] Exclusions made either by the legislature or by decision-makers have, however, a substantial impact on the instrumental success of the scheme, rendering some of its apparent radicalism as much symbolic as real. As Klar put it:

> The ambiguities in the concept of personal injury by accident, the lack of adequate statutory definition, and the absolute exclusion from the program's coverage of those persons disabled not as a result of accident, but as a result of disease, infection, or the ageing process have combined to present the New Zealand program with its most serious ideological, administrative and practical difficulties.[40]

As has been noted, there are special difficulties associated with the exclusion of sickness from the scheme, in part derivative from the problems of interpreting what amounts to 'accident'. The implementation of a narrow, legalistic interpretation of 'accident' may be the result of a number of factors which take little or no account of the philosophical underpinnings of the scheme itself. Financial constraints may have an impact, as may interpretational variations based on policy grounds, just as they do in fault based systems.[41] For example, economic considerations may be particularly important when the state and not the individual bears the cost of awards. Whilst there is evidence of a high success rate in claims made to the Accident Compensation Corporation[42] (as indeed, there is even under the fault-based system[43]), '[w]hen the Accident Compensation Commission decides whether there has been a personal injury by accident it is making a decision about its own money and resources'.[44] Although it would seem currently that the Accident Compensation Corporation faces no devastating financial problems, there is nonethless some evidence that decisions are being taken on the basis of criteria which are theoretically foreign to the nature of the scheme. Palmer, for example, a noted commentator on the no fault scheme, notes with some concern that, at least in some cases:

> There is a ring of the old tort law in the language used in the review decisions which talk about 'risk' and 'remoteness'. The approach seems to be misconceived. The aim of extirpating the common law action must be kept to the forefront or thinking on the subject.[45]

As has been noted, the definition of accident for the purposes of the scheme excludes sickness or disease and also pregnancy unless arising from a criminal offence. 'Accident' is deemed to be an event and not a process, logically excluding these categories. However there are also claimants who will be excluded on the grounds that their damage is the result of disease, even where actual harm came to light following an event in the nature of an accident. Moreover, whilst the distinction between accident and sickness may in some cases be clear, in others it may be highly problematic and result in fine decisions being made. In one appeal case it was said that:

> The boundary line between an accident injury and a disease injury may be hard to discern at times but there is no doubt that the legislature requires the line to be drawn and the interpreter of the Act must take cogniscance of this.[46]

Although there seemed to be no formidable opposition to the introduction of the accident compensation scheme, little systematic work has been done to assess the views of those either who have been given cover under the scheme, or those who have been refused it. Financial compensation under the New Zealand system is generally made by way of periodic payments approximating to 80% of salary, with a limited lump sum also available in some cases.[47] Inevitably, in monetary terms, such awards will compare unfavourably with the sometimes substantial awards made in those countries which adhere to the tort or delict system. Thus, whilst those who are excluded from the new scheme might well be expected to demonstrate the same dissatisfaction as those unsuccessful under the tort system, those who have received awards under the accident compensation scheme might also feel that the financial limits set render compensation less than completely satisfactory. As Klar[48] notes, quoting work undertaken by Lloyd-Bostock,[49] there seems to be an ingrained attitude - at least in those communities where the common law action remains the primary source of redress - that lump sum (and substantial) awards are an inherent and desireable feature of compensation. If this is so, it may lead to theoretical or emotional dissatisfaction with a system not based on fault, and moreover to rejection as unsatisfactory of periodic awards of damages which relate to actual need rather than to projected loss.

Under the New Zealand scheme, damages are by definition related to needs not deeds, and are designed to mitigate loss rather than to indulge in the kind of assessment of quantum which is a feature of common law actions. The system 'aims rather at providing a wide range of benefits which are designed to cushion the effects of an accident'.[50] Compensation takes on a somewhat different complexion, being less concerned with mere financial recompense and more interested in rehabilitating victims and minimising financial difficulties. Moreover, the potential for deterrence, which is claimed by some to be a desirable feature of the negligence action, is expressly rejected by Woodhouse. Avoidance of accidents is central to the accident compensation scheme, but is not seen as likely to be achieved through any minimal deterrent effect which the common law action might have. Rather, state resources should be used to create meaningful accident prevention. However, it is disappointing that both the collection of data about accident prevention (which is inevitably tied up with such a system of 'social insurance') and rehabilitation seem to have been in practice less important in New Zealand than was initially anticipated.

There are, moreover, further and very fundamental concerns generally expressed by tort lawyers about the nature of the accident compensation scheme. The right to raise an action in the traditional manner through courts of law is jealously guarded by proponents of the tort or delict system, and the general removal of this right under the no fault system is regarded by some as one of its most worrying features. As Klar says:

> The challenge presented to tort lawyers by the program's abolition of common law rights for personal injury victims is obvious: can the cause of action be eliminated without any appreciable harms to the society and in fact with benefits to the society as promised by tort law abolitionists?[51]

One way of answering this question is to examine any practical shortfalls of the new system and to attack them as ideologically central to the system itself. Thus, if the no fault system fails <u>actually</u> to provide comprehensive cover - as it does - then it can be argued that it has failed to provide an adequate and effective structure which could justify the excision of actions based in tort or delict. This type of attack interestingly bears a close resemblance to the kind of argument often used against the tort or delict system. Proponents of the no fault approach might equally argue that the mere existence of a right to sue in courts is not by itself the mechanism which provides vital protection for the individual. Rather the facilitation of general compensation is what is crucial to the credibility of any scheme, and this cannot be achieved through tort or delict. Whilst both arguments have some weight, it should be noted that when used against the no fault system they are largely functional. When used against the fault based action, however, they are essentially philosophical and therefore more difficult to rectify within existing structures.

In defence of the tort or delict system it should be noted that it was never designed to compensate everyone and it is therefore scarcely an appropriate criticism that it fails to do so. Those opposed to the continued use of actions in tort or delict may well wish to argue, then, that the very rationale for the action is itself wrong, since every injured or damaged citizen should be entitled to assistance from the state - precisely the type of argument used by Woodhouse. However, it is unarguable that the accident compensation scheme did purport to offer comprehensive cover, and the fact that it does not is a valid structural, if not theoretical, criticism.

Moreover, given the fact that the intended comprehensive nature of the New Zealand scheme meant the sweeping away of the common law action in all cases of personal injury by accident, it is essential to its credibility that internal decision making should not be rigid and inflexible. After all, if the scope of the scheme is narrowed by refining terminological interpretation, then not only will some citizens have no recourse through this system, but because of the limitations on the use of the residual common law action, they will also have no right of action through the civil courts unless fault can be proved and their injury was not caused by 'accident'.

Although much of the critical comment on the no fault system relates to its practical failures, there is still a philosophical problem felt strongly by some. It will never, it is claimed, 'substitute for the common law cause of action' and will 'reflect neither its ideology nor its functional objectives'.[52] But it was never, of course, intended to do this. Indeed the Woodhouse Report was as critical of the objectives of the common law action, as it was of its practical manifestations. The aim of the accident compensation scheme was precisely to remove these elements from consideration and to replace them with a comprehensive and humane system of victim support. Indeed, much of the ideology of the common law action could not be accommodated within a state funded and comprehensive system of social insurance.

Further criticism can, however, be levelled at the philosophical underpinnings of the scheme. Whilst the Woodhouse Report focussed its critical attention on the negligence action, there were, of course, other possible actions available under the common law. However, the institution of the accident compensation scheme essentially swept the common law board clean where the injury complained of could be deemed to have been caused by accident. As Klar says:

> ...the legislation bars all civil proceedings which relate to damages arising directly or indirectly from personal injury and death by accident, and not merely actions which would have been based on negligence law. This includes actions in occupier's liability, product liability, nuisance, strict liability, intentional torts, and so on. Causes of action which have never been the subject of criticism from tort law opponents, and which do not share the same defects as negligence law, have been eliminated.[53]

This must be a considerable cause for concern, and the problems associated with it can only be obviated by a truly comprehensive and non-discriminatory scheme, or perhaps even mitigated by a mixed system of liability which excludes the problems of the negligence action while ensuring that the difficulties of the other forms of action are mitigated by legal change. It is the fact of compensation which is said to be crucial in New Zealand, rather than the form of action necessary to obtain it - at least where the system operated conforms to fundamental principles. The exclusions from eligibility under the New Zealand scheme would seem to weaken its impact considerably. Rigid or narrow interpretation of eligibility serves merely to render the scheme unsatisfactory and inflexible.[54] Whilst extra legal factors are routinely imported, or expert testimony used as definitive of the issue, in medical negligence cases, decisions in the accident compensation scheme may additionally be open to bureaucratic or political influence. Thus, policy factors could equally influence the operation of a no fault system. The following section will consider the place of the patient in the no fault system, and seek to identify whether - unlike the systems described above - this scheme offers a framework within which the patient's rights are adequately protected in medical matters.

## Medical Misadventure[55]

It is the purpose of this section to focus on the particular example of medical misadventure as a means of analysing what, if any, are the problems facing decision-makers and claimants under the new scheme of liability in New Zealand. One area of particular interest in jurisdictions retaining common law actions has been that which relates to medical negligence.[56] In some countries there is said to be an explosion in litigation of this sort, and patients and others have sometimes been disaffected by the attitudes adopted by courts in such claims.[57] In Woodhouse's terms, medicine might be seen as an area in which his justification for state compensation is peculiarly appropriate. Medicine is a clear example of society's desires for progress, it is an inherently risky process and, therefore, one might think, an area in which claims would be frequent, whatever the skills of the doctor.

Policy factors in common law countries have been used to expand the liability of some individuals and groups, but there is a recurring suggestion that '[t]here has been a surprisingly strong emphasis on policy, not so much to expand, but rather to limit, the application of negligence to doctors.'[58] The Pearson Commission in the United Kingdom noted this trend indirectly in its assessment of success rates in personal injury actions.[59] Whilst the general success rate was high, in medical cases it was considerably lower, and although there may be a number of factors involved in this finding (in particular that settlements are often made out of court) it would nonetheless at first sight seem likely that the victims of medical accident (which the Pearson Commission felt to be the largest group[60]) would be considerably benefited by a system such as the accident compensation scheme. No longer would the medical profession be subjected to ever-increasing public allegations of negligence in their high-risk practice, nor would patients find themselves dissatisfied with the legal process, when claims are heard privately, need not depend on allegations of professional fault and are settled relatively quickly.

Courts in the United Kingdom have frequently referred to the problems generated by a laissez-faire attitude to medical claims, and condemned the impact of readily available compensation on health care.[61] Substantial awards of damages have come under fire also as having an impact on the profession and on the provision of health care.[62] Under the New Zealand scheme such problems would, in theory, have less relevance. The doctor would pay no more in terms of insurance were the patient to be compensated, his or her reputation would remain intact, the patient would receive some (periodically reassessed) assistance, and since awards are designed to cushion rather than to replace loss there would be no need for the huge lump sum awards increasingly made in some countries.[63]

Not only the terminology, but also the underlying assumptions of the negligence action were modified, if not dismissed, by the Woodhouse Commission. 'Misadventure' was used to cover the unlooked-for side-effects of medical treatment thus avoiding the value judgements inherent in the terminology of negligence. Theoretically, as Blair points out:

> It is plain that 'medical misadventure' is broader in meaning than <u>medical negligence</u> and that to qualify for compensation...it is sufficient for a claimant to show a causal relationship between a medical mishap amounting to medical misadventure and his injury.[64]

Misadventure, therefore, contains no necessary element of negligence although clearly it could. Rather it is an 'event arising out of medical treatment which causes undesigned injury to a patient which may not be regarded as an illness flowing naturally from the treatment'.[65] The Accident Compensation Corporation itself gives to doctors an apparently straightforward account of what is meant by medical misadventure:

> The effect of the definition is that it is not necessary to show that there has been negligence on the part of a medical practitioner before a claim will lie for medical misadventure. The definition embraces the cases where the correct procedures were carried out but where a mischance or accident, unexpected and undesigned occurred.[66]

This seems quite straightforward, and if there is no need to establish negligence then the assumption must be that patients are more likely to receive compensation under the accident compensation scheme. But is this so?

What any citizen has to establish in order to be compensated under the scheme is that his or her damage was the result of personal injury by accident (an unexpected or unlooked for event), that it did not therefore amount to sickness or disease, and - in the case of the patient - one possible way of showing this is to demonstrate that the injury was the result of medical misadventure, which was designed as an example of what could be personal injury by accident. It was not a different definition of personal injury by accident nor was it intended to impose a further evidential burden added on the victim.

An analysis of some of the cases which have been decided under the accident compensation scheme will serve to demonstrate whether or not the patient is more likely to be compensated within the framework of these determining factors. Whilst the two elements (personal injury by accident and medical misadventure) were not necessarily devised as different and distinct, it is intended in this section to deal with them in a seperate manner in as much as this is possible. Thus, consideration will first be made of personal injury by accident in the context of its relationship to sickness and disease, and secondly of medical misadventure, and in particular the unexpected nature of the event.

Accident and Disease

> The difficulty [of defining accident] is especially apparent in the area of response to medical and surgical treatment. People differ widely in their inherent attributes, their life styles, their dietary habits and so on. The reaction therefore to particular medical or surgical treatment is likely to differ widely from individual to individual.[67]

This statement makes clear some of the difficulties particularly associated with distinguishing between 'accident' and sickness, which have already been noted. Further, it points to the special problems which occur when the accident arises as a part, or as the result, of medical treatment. Nowhere is it more difficult to make such a differentiation than in this context, where injuries or damage may arise spontaneously in the course of treatment. When reviewing some of the cases, there are two points to bear in mind. First, that a distinction has been made between accident and disease, and that this will be maintained by the decision makers. Second, that accident must be an unlooked-for and unexpected event (according to Woodhouse, unlooked-for by, and unexpected to, the person to whom it happens) arising from an external cause.

The difference between accident and disease is made clear in one case, in which it was held that the development of an embolus after surgery was not an 'accident' even although the patient did not expect it.[68] Such a development is by its nature a process of sickness or disease - not an accident. Not only is it a progressive condition, but it is also a known possibility of surgery and therefore not accidental. The second point will be considered later.[69] The distinction between accident and disease is particularly problematic in medical cases, primarily because the results of badly or inadequately administered treatment, or of a failure to treat, may often manifest themselves as a complication or continuation of the pre-existing disease.

Under the common law, it is possible, although rare, for doctors to be held liable for a failure in diagnosis if this is negligently done.[70] The responsibilities of doctors include a duty to treat reasonably, which may include accurate assessment of condition.[71] Although failure to diagnose is not always negligent, it may be, depending on the circumstances of the case. One immediate problem of the accident compensation scheme (as far as the patient is concerned) is that there is almost no way (even where there is negligence) that a failure to treat or diagnose can be deemed to be personal injury by accident. The reasoning is as follows:- whatever harm has been caused as the result of failing to make an accurate diagnosis or omitting to treat is harm which resulted from the original illness itself. Because illness is not accident, then it cannot be compensated under the scheme. Although there remains a residual right to raise a common law action, only rarely will the courts be prepared to hold a doctor liable in these circumstances. The patient is, therefore, practically denied redress for what may be major disabilities. As one Appeal Decision put it '...one must be satisfied that the omission by the doctor to either diagnose the disease or to discover the condition during the operation process materially contributed to the death.'[72] The test is, therefore, very stringent, and difficult to meet. As one Review Decision points out:

> ...a failure to diagnose leading to the true ailment not receiving medical treatment can rarely, if ever, be the foundation for a claim under the Act, in that the patient's condition remains attributable to the ailment alone.[73]

Although the outcome is achieved by a different route, the impact of the new scheme is much the same as that of the common law. Failure to treat or diagnose will virtually never be compensable under the Accident Compensation Acts. In fact, it may be the case that the patient has a relatively better chance of success under the common law, an outcome surely not designed or predicted by the accident compensation scheme.

Nor are problems solely associated with clear failures to treat or diagnose. Where the patient involved has a pre-existing condition which comes to light or is exacerbated by an event in the nature of an accident, there may be further difficulties in assessing what actually is the cause of the harm. It is worth noting that only in cases such as these is cause actually relevant to the assessment of eligibility, and that this results from the problematic distinction between accident and disease. A clear example is the case of a person with a pre-existing back condition which is exacerbated by a fall. Now, vast numbers of people, especially among the older groups in the community, will have some back problems as the body begins to wear down. The fall is an accident within the meaning of the Act, but the actual harm is the result of the pre-existing back condition. Thus the person will not receive compensation under the scheme because the damage is caused by illness and not accident.

A second problem for the patient relates to an inherent attribute of an 'accident' for the purposes of the scheme - that is, its unexpectedness. As has been seen, the Woodhouse Commission related the unexpectedness element directly to the person concerned. Thus, if something unexpected and caused by external events occurs then compensation follows. In the normal run of the mill case this will be precisely the situation. There is, however, a notable difference in the case of those unexpectedly injured in the course of medical treatment. Consider this statement:

> It is against human experience that the results of medical treatment will always be favourable....There must be few significant medical treatments that do not contain some risk of the results being contrary to hopes and expectations and some risk of developments adverse to the patient's condition. The likelihood of the risk eventuating, the gravity of the possible consequences, and the balance struck between those attendant risks and the advantages that might be gained, are factors influencing the decision as to whether the treatment should be given and accepted. But if adverse developments or results are known to reasonably informed medical opinion to constitute a known risk of the treatment, and that risk then materialises, can it be said that those adverse risks are personal injury by accident? In my view a person who accepts (or in some cases is deemed to accept) medical treatment is to be regarded as accepting the possibility that the known risks may eventuate. It is not to be considered as an 'accident' to him if the consequences that are at risk do in fact occur.[74]

There are a number of interesting features in this well-used and authoritative statement. First, it seems to make it clear that only those risks which are unexpected will be covered by the scheme. This, of course, is entirely in line with the Woodhouse view and the routine interpretation of accident under the Act. However, Woodhouse also made it clear that the unexpectedness element was personal to the victim. Here, however, is a situation where the unexpectedness question was determined by reference to the state of knowledge of a third party. In other words, if the doctor knows of a risk, even if patient does not, then the occurrence of that risk (which is unexpected as far as the patient is concerned) is not deemed to be personal injury by accident.

Moreover, the further implications of this approach are of particular concern, given that there are important reasons for acknowledging the rights of patients which have stimulated most jurisdictions throughout the world to make serious attempts to develop a doctrine of consent which is meaningful to the patient. Lack of consent to treatment clearly cannot be covered by the scheme unless it is particularly gross - for example, carrying out a different operation from the one to which consent was given. There is also in the above statement a clear view that patients may be deemed to have consented to treatment whether or not they have been informed of the likelihood of certain (perhaps major) risks. It is precisely this which is inimical to the development of appropriate doctrines about consent in medical treatment, and to protection of the right here described to make decisions based on adequate disclosure of information.

In the same case, a rule of thumb was given which has been used in most subsequent cases, and which is also worthy of note. Normal risks of medical treatment (whether or not they are unexpected by the patient) will not constitute personal injury by accident, but:

> ...it is possible that some adverse consequences of medical treatment might be so rare or so grave that they should fairly be regarded as constituting personal injury by accident. I would consider that entitlement would be granted in such circumstances only if the following qualifications were met:
> (a) the risk that eventuated was a rare and remote one;
> (b) such risk would not reasonably be taken into account when considering the wisdom of the treatment proposed;
> (c) the consequences were grave and totally disproportionate to the significance normally attached to the treatment;
> (d) such consequences were clearly beyond the extent of adverse consequences that would normally and reasonably be contemplated as included within the risk.[75]

The impact of this view, which has been accepted by subsequent decision-makers, is clear. First, there is the requirement that the risk has to be rare, grave or remote. The outcome of this is that only the most serious and unusual risks could ever constitute personal injury by accident. Moreover, the rarity of the risk means that - in this view - it would not normally be considered, that is it need not even be disclosed to the patient. If this is so, the patient would seem to have no protection against doctors minimising or omitting to inform them of known risks which might well have affected the choice as to whether or not to undergo the treatment.[76]

Nor can the frequent use of words like 'reasonable' have more than a symbolic meaning, since it is unclear in the accident compensation scheme whether 'reasonably taken into account' relates to the patient or the doctor. In view of the general tenor of this decision, it would seem that, most likely, it does not relate to the patient, but rather to the doctor. In this respect, the test resembles that used in some other jurisdictions where the criteria for assessing the propriety of non-disclosure are related clearly to the 'reasonable doctor' standard.[77] The development in New Zealand of anything approaching a doctrine of 'informed' or real consent is therefore unlikely. There is no incentive for doctors to make any kind of disclosure to the patient of risks which they fear may deter the patient from undergoing the doctor's chosen therapy.[78] Equally, if the patient is disabled by a known risk whether or not he or she is told about it, any disability will not be covered by the the accident compensation scheme. Of course, failure to develop a doctrine about consent may be less significant if compensation is in any event available, since there is no implication that doctors maliciously fail to make disclosure. Although it would not vindicate the right described here, it would at least permit of redress. However, even under the accident compensation scheme - given that it does seem to apply tests for exclusion from compensation - an acceptance of the patient's right to receive information may be crucial.

## Medical Misadventure Revisited

What then is medical misadventure? It is not disease, and it is not failure by the doctor to make an accurate diagnosis or to treat. Nor is it related to the eventuation of disability through one of the risks of medical treatment actually ocurring - even if the risk was unknown to the patient. In fact, the circumstances which would entitle the patient to compensation under this scheme relate very closely to those which would be compensable under the fault based system, which the accident compensation scheme was created to replace. The authoritative definition of medical misadventure is contained in one review case, and is as follows:

> Medical misadventure is when
> (a) a person suffers bodily or mental injury or damage in the course of, and as part of, the administering to that person of medical aid, care or attention, and

> (b) such injury or damage is caused by mischance or accident, unexpected and undesigned, in the nature of a medical error or medical mishap.[79]

This statement equates medical misadventure to situations where there is medical error or medical mishap. It is worth noting that the word 'negligence' is never used in this context. Indeed it is clear that the intention of the legislators was that misadventure should amount to more than just negligence. As has been said:

> It is plain that medical misadventure is broader in meaning than medical negligence. If Parliament had intended that cover for this kind of injury was to be restricted to that resulting from negligence, it would have used the well understood word 'negligence' rather than invent the phrase 'medical misadventure'.[80]

If the term 'medical misadventure' is broader in meaning than medical negligence then one would anticipate that this would inevitably mean that more cases would fit within its terms. The fact that fault need not be proved might also encourage liberal decision-making within the system since the doctor's reputation, so often raised as an issue under the common law,[81] would not be damaged where no attribution of fault is made. However, it has been seen that the term may in fact not be significantly wider than medical negligence, and it is submitted that - in fact - the two correspond rather closely. Indeed, Palmer has noted that in these cases there is a clear similarity between the tests used for medical misadventure and those used for medical negligence.[82]

Since it is now the trend in most legal systems that a failure to obtain real consent is dealt with under the laws of negligence rather than as a form of assault,[83] then there is a major emphasis on the reasonableness of any failure to make disclosure. As has been seen, reasonableness is often decided with specific reference to what doctors (or a reputable body of medical opinion) regard as being reasonable, rather than what the patient regards as reasonable.[84] Even in those jurisdictions which apply the reasonable patient standard, medical evidence is vitally important to the assessment of the likelihood of risk eventuation, which in turn affects what the reasonable patient might be expected to do.[85] Under the accident compensation scheme, the same types of assessment are made, with the crucial difference that even failure to disclose material risks would not necessarily render the doctor liable. The doctor's knowledge is what is central to the definition of medical misadventure since it is crucially dependent on the concept of 'accident'.

The patient, then, is under two major disadvantages. First, since the effect of medical behaviour may be that his or her disease continues unabated, this will remain uncompensated since it is not a personal injury by accident. Moreoever, there is no pretence at developing a consistent ideology in relation to obtaining meaningful consent since the patient is the only person whose knowledge of risk is irrelevant to the calculation of unexpectedness which is central to the definition of accident. Since any action raised at common law under the residual power has little chance of success, given the tests used for negligence,[86] then the patient is seriously disadvantaged when excluded from the scheme.

Medical misadventure, then, is certainly not intended to be the same as medical negligence, although there is a certain similarity in the tests used to establish them. Moreover, it may even be that in some cases the interpretation of misadventure is narrower than the interpretation of negligence. Misadventure is defined in terms of medical error or mishap, terms which have been authoritatively reviewed in one leading decision.

> 1. '<u>Medical error</u>' means the failure of a person involved in the administering of medical aid, care or attention to observe a standard of care and skill reasonably to be expected of him in the circumstances. Medical error can relate to the correctness, the propriety, the adequacy, and the quality of the medical aid, care or attention given. Error may arise either in the performance of that aid, care or attention, or in the diagnosis, judgement, or preparation that leads to it. It arises only if the service to the patient is of a lower standard than was reasonably to be expected in the circumstances....<u>The test may be considered similar to the test of negligence in the common law system, but it is not intended that they should necessarily coincide</u>. (emphasis added)
> 2. '<u>Medical mishap</u>' ...as a generalisation, but not as a definition, 'medical mishap' normally describes the situation when there is the intervention or intrusion into the

> administering of medical aid, care or attention of some unexpected and undesigned incident, event or circumstance, of a medical nature, that has harmful consequences to the patient.[87]

Ultimately, then, medical misadventure can be described in almost exactly the same terms as medical negligence. The above definitions explain circumstances in which - even under the common law - a claim for damages has a reasonable chance of success, the latter by the use of the doctrine of <u>res ipsa loquitur</u>.[88] Clearly, 'medical error' relates very closely to the accepted view of negligence, and 'medical mishap' seems to envisage situations where, for example, a swab is left behind in a patient or a surgical instrument breaks and causes harm.[89]

Indeed, in many of the accident compensation decisions on medical cases there is a striking similarity between the kinds of tests used for medical misadventure and those used in assessing negligence under other systems. However, there is a further problem for the claimant under the accident compensation scheme in that the damage caused has to be in the nature of an accident and not a continuation of the existing ill-health. In many cases, as has been seen, it may be that the necessary distinction will be hard to make. Damage may not readily be attributable either to accident or to the pre- existing complaint, and where there is doubt as to attribution, the scales will weigh in favour of disease. As Blair puts it:

> If the medical evidence is in such terms as to leave the Commission with the impression that, as between accident and disease, the scales are evenly balanced, then it cannot be successfully contended that the condition laid down by the statute has been met, and the claim for compensation is therefore not established.[90]

Narrow decision making is sometimes claimed to be a feature of medical negligence cases in some jurisdictions and seems to be not uncommon in the accident compensation scheme, to the clear detriment of the patient. However, the patient in the accident compensation scheme is perhaps even more disadvantaged than his or her counterpart in the common law. Whether or not the doctrine of informed consent is officially recognised in British courts,[91] there is nonetheless a commitment in general to its aims, however ineffectively that commitment may be translated into practice. The New Zealand scheme seems almost to provide a disincentive to the obtaining of informed consent. Further, the patient who is unsuccessful under the accident compensation scheme may well be reluctant to attempt a subsequent claim by using the residual right of action, having perhaps already been through a process of hearings and appeals. The well-known vagaries of the negligence action - paradoxically so heavily criticised by the Woodhouse Report[92] - may well be more strongly felt when one process has already been tried and has failed.

It seems clear that by making the distinction between accident and disease, the intention of the legislators and the Woodhouse Commission was to limit the availability of compensation to certain groups. It has already been pointed out that this distinction is philosophically illogical and pragmatically problematic. In the case of the injured patient these problems would seem to be exacerbated by the apparent reluctance of decision-makers to award compensation in medical cases. As Hughes says:

> ...it is suggested that there has been an unfortunate tendency to restrict the concept of 'medical misadventure' rather than approaching it in a liberal way so as to incorporate an expanded 'injury' element in the definition of 'personal injury by accident.[93]

The disaffected patient is, then, unlikely to be more readily compensated under the accident compensation scheme than under the negligence action, and indeed may sometimes be in a worse position given the range of qualifications which apply to medical cases.

Moreover, there is a further problem in respect of the level of awards made under the new scheme. It is axiomatic that damage resulting from medical treatment may well be more severe than the level of negligence or misadventure which it represents. In other words, a small slip by a doctor, or the occurrence of an unavoidable risk, may result in major and grave damage to the patient. Under the tort or delict system the extent of the damage and the long-term prospects of the patient form part of the assessment of damages.[94] This has been criticised in a number of British cases as representing too substantial an award when the person is incapable of understanding or experiencing the loss,[95] although it is a well established feature of the negligence action. The New Zealand scheme deals expressly with this type of award. Not only are damages awarded according to needs (up to certain limits) but substantial financial awards are expressely restricted by the legislation in respect of all groups, and in particular those who have no awareness of that loss. As Blair says:

> It should be noted that the section expressly provides that the Commission, in assessing compensation, shall have regard to the injured person's knowledge and awareness of his injury and loss....In the common law there has been some controversy regarding the amount of compensation that should be awarded for pain and suffering and loss of amenities when the accident victim has little or no awareness of his loss. However, it now seems to be accepted that in such circumstances only moderate compensation under this heading should be awarded.[96]

Thus, compensation will be subject to limitations on the grounds that the person injured does not understand the change in circumstances. Klar sees this as a real problem of the new scheme, and claims that therefore 'there has been a very uneven replacement of common law rights by accident compensation rights'.[97] Limitations on awards apply, of course, to all claimants under the scheme, and there is little doubt that some may be disaffected by the considerably lower awards likely to be made. Klar, in fact, claims that the level of compensation is highly significant to the very nature of the accident compensation system in that:

> It is clear from the attempts made by victims who have been intentionally or recklessly injured to use the common law rights of action, that the social justice aimed for by the Woodhouse proposals has resulted in grave injustice to some. This ought not to be a feature of social reform.[98]

The level of award made may well be problematic to those who were reared on the common law system, but it is to be hoped that the problem is resolved in future generations, since it may be that dissatisfaction in this area is as much a function of outdated expectations as it is a critical point about social justice.

## Accident Compensation and the Doctor

It is not, however, only the patient who may suffer as a result of restrictive interpretation of the accident compensation scheme. Dismissal of a claim by a patient may well result in a civil action in negligence being brought against the doctor placing him or her in much the same position as his or her colleagues in other jurisdictions. It has frequently been pointed out that, given the system of medical insurance offered by defence organisations, it is only the doctor who seems to have a defence who will end up in a court of law.[99] Equally, if damage is not deemed to be personal injury by accident in the accident compensation scheme an action at common law may still lie, and the doctor remains at risk of civil action. As Osborne notes '[i]t is still open to a patient to bring an action in negligence against a doctor, surgeon or hospital so long as the patient cannot be said to have suffered personal injury by accident.'[100] Narrow interpretation does not necessarily serve the interests of medicine - indeed it may serve to leave the physician in a vulnerable position.

## Summary

The Woodhouse condemnation of the negligence action coupled with the desire to include more people within the ambit of accident compensation demanded the use of a less narrow and value laden terminology than that of negligence. To confine the award of compensation to circumstances equating to negligence, with the implication of fault, runs completely contrary to the ideology of the scheme. Equally, in theory at least, no special allowances are made for any group whose behaviour may contribute to the occurrence of harm to others. Certainly doctors are given no special status under the Accident Compensation Acts, and the patient may therefore expect to be treated in the same way as any other potential claimant.

Unlike the tort or delict system, which concerns itself with factors extraneous to the actual harm, the accident compensation scheme should be indifferent to them. Whilst judges, and indeed some commentators, in the common law jurisdictions of the world have expressed disquiet about the impact on the practice of medicine of a finding of negligence in respect of a doctor,[101] theoretically such concern is foreign to the New Zealand scheme and should not contribute to the assessment of eligibility for compensation.

However, there is some evidence that:'[t]he Commission has interpreted the new phrase [medical misadventure] cautiously with the result that doctors remain at common law risk to some extent if the interpretation be correct.'[102] Indeed, the evidence tends to suggest that 'medical misadventure' has been interpreted not merely as an example of personal injury by accident, but almost as a further test to be applied in establishing eligibility for compensation under the scheme. This is most clearly demonstrated in cases relating to the risk factor involved in all medical treatment.

Statements from decision-makers in the accident compensation scheme and in cases relating to it are remarkably similar to those used by some judges in the tort or delict system. For example in A.C.C. v. Auckland Hospital Board[103] the judge almost echoes the words of Lord Denning in the case of Roe v. Ministry of Health[104] by saying that '[i]t is the nature of medical and surgical treatment that unexpected and abnormal consequences may follow...'[105] The expectation that adverse consequences may follow medical treatment is deemed to have an impact on their status as 'accidents' or 'misadventure' for the purposes of compensation. For example, the judge continued:

> Where there is an unsatisfactory outcome of treatment which can be classified as merely within the normal range of medical or surgical failure attendant upon the most felicitous treatment, it could not be held to be a misadventure.[106]

There is, as Palmer says, 'a ring of the old tort law'[107] in such a statement - almost as if the impact of the occurrence of the risk on the patient is less significant than the interests of medicine or the protection of the reputation of the doctor. Under the accident compensation scheme such factors should be irrelevant. Nonetheless '[t]he Commission by its restrictive interpretation seems concerned to avoid sliding down the slippery slope and compensating illness or death every time medical treatment fails.'[108]

Since the outcome of failed or risky medical treatment may be illness, then the distinction incorporated into the legislation between accident and disease becomes relevant. Whilst this distinction has been described as ilogical, it may be less problematic if consistently applied. Thus the patient may seem to be in no worse a position than anyone else whose disability or loss flows from sickness rather than accident. However the patient is in a different position, partly because he or she is almost by definition already ill and the problems of distinguishing between illness and accident are therefore exacerbated. As Klar points out there is a kind of rough and ready distinction drawn by the Corporation, but this distinction is not without problems.[109]

Thus, the intervention of medicine is not usually deemed to be an external event for the purposes of the scheme, even although the risk which actually occurs and causes damage is not a feature of the pre-existing disease, but rather of the treatment for that disease. In other words, if A suffers harm or loss as the result of an illness then he or she is clearly excluded from cover under the accident compensation scheme - all the symptoms relate exclusively to the illness and are not compensable. However, if A seeks treatment, then any damaging side-effects are risks not of the illness but of the treatment. If this distinction were accepted by the Accident Compensation Corporation, then A could be compensated in the latter case since the treatment is external to the disease for these purposes. This, however, has not been the interpretation adopted,[110] and in fact A would not be compensated in the latter case unless the risks were so rare and so grave as not to be anticipated even by the doctor.

Moreover, there is a difficulty with the concept of 'unexpectedness' which is central to the definition of accident used in the scheme. To say that adverse side-effects are not 'unexpected' rather than not known may be to stretch the unexpectedness factor considerably. Even where the patient is informed of possible risks, it may, in cases where the risk factor is small, be stretching common sense too far to suggest that because they are known they are also expected. Indeed, if one looks at other categories of claim it can be seen that foreknowledge of possible risk is not held to render the harm 'expected'. For example, the well-known risk to participants in certain contact sports does not preclude compensation in the event of that risk occurring. One can only hypothesise that the essential difference between the two cases relates to the involvement of a third party, that is the doctor. If this is so, then there would seem to be - even under the accident compensation scheme - an apparent reluctance to attribute responsibility for harm to medicine, perhaps because it is seen as itself a social 'good'. The only other possible explanation would seem to relate to the involvement of a third party, whoever that may be. However, there is third party involvement in other situations yet it is not deemed to affect the claims of the damaged individual.

In medical cases, some relatively sophisticated interpretation of language has been indulged in as a means of avoiding the admission that the damaging event was an accident and therefore compensable. For example, in one Review case it was said:

> In relation to many forms of medical or surgical treatment there are known complications or consequences and some of them may, when they occur, be unexpected by the patient although anticipated by the doctor or surgeon....That degree of unexpectedness, however, does not mean that the complications or consequences must not only be adverse to the patient's well-being but must also have been unexpected by the doctor or surgeon giving the treatment.[111]

It is open to question why such an interpretation should be adopted by the Accident Compensation Corporation. Moreover there is no necessary implication in any other type of claim that a risk has been accepted, whether or not the person was aware of its existence, merely because someone else knew of the possibility of the risk eventuating. What such an interpretation seems to do is to reinforce the notion that patients tacitly accept the risks of treatment whether or not these are fully or partially explained to them. In other words, this interpretation may be a straightforward adoption of some of the arguments, currently raging in the common law, into the new scheme. One further possible explanation for narrowing the scope of liability in this area is the desire (again common in other jurisdictions) to avoid the ascription of liability in medical cases.

It should be noted, however, that the accident compensation scheme is not in theory concerned with the ascription of liability but rather with the amelioration of loss and harm. The concept of personal liability, which is central to the tortious or delictual action, is not of relevance in this system, except, it would appear, in medical cases. If this is the case, then it can be seen that in cases involving patients the decision-makers <u>are</u> considering 'blame' or 'fault' and taking account of factors extraneous to the claim itself in assessing eligibility. The adoption of such an approach leaves the patient in a vulnerable position. Denied access to the accident compensation scheme, he or she is left only with the option of using the residual common law action. Yet Woodhouse was highly critical of this action, and it has been claimed that it is often particularly unsuccessful in medical cases.[112]

## Conclusions

As a result of the interpretation used by the decision-makers in the accident compensation scheme, some citizens, by virtue of their already vulnerable position, become even more vulnerable. They cannot claim successfully where no treatment is given or where the wrong treatment is provided. They must face the inherently tricky task of showing that their injuries result from accident and not disease. Without resorting eventually to the tort based action they cannot claim in respect of a lack of real consent to treatment, and they are forced to accept risks which may never have been disclosed to them. In many cases they will be thrown back on the much-maligned negligence action. The aims of Woodhouse to support and rehabilitate the work force cannot be achieved in this way.

There are further implications flowing from this interpretation which also have serious repercussions for all patients. There is clearly no incentive within the scheme to protect the patient's right to make knowing choices about the desirability of treatment from his or her point of view if consent (or at least acceptance of risks and benefits) is implied from acceptance of the treatment. Problems of information disclosure will be left to the common law with the possible exception of those cases where consent was given to one treatment but another was actually undertaken. Even under systems which use the traditional approach such cases are given special protection,[113] but they will amount to only a very small proportion of the total potential cases.

In any event, failure to disclose the existence of a known risk which may have affected a patient's choice, but which did not in fact eventuate can never be compensable under the accident compensation scheme, since it does not and cannot equate with the definition of eligibility. Evidently, if the insult is to integrity and does not result in incapacitation from work, then there is no rationale for compensation in Woodhouse's terms. Thus, changes in interpretation could offer compensation in cases where harm resulted, but could never provide a vindication of the abstract right, since the kind of harm caused is not legally recognised.

A broad interpretation of personal injury by accident and medical misadventure would include negligence as well as other accidental mishaps which occur in medical practice. It would also minimise the common law risks to the doctor and ensure compensation for the patient who is damaged whether or not by anyone's fault. However a review of decisions would suggest that in fact only limited categories of medical events are deemed to be included in the cover offered by the accident compensation scheme. These are roughly as follows:-

1. Situations where the doctrine of <u>res ipsa loquitur</u> would have been applied under the common law;
2. Accidental damage to, or breaking of, implements used in the medical transaction;
3. Acts of operational negligence.

The situations excluded would be:-

1. Failure to treat or diagnose accurately;
2. The occurrence of risks known to the doctor but not necessarily to the patient;
3. Failure to obtain make disclosure of sufficient information to permit a morally satisfactory decision by a patient.

Thus, the new scheme neither covers all aspects of what might have been negligence under the pre-exisiting system nor does it cover all situations which would equate to a common sense view of what amounts to 'accident'. As Cripps says:

> The proposition that personal injury caused by negligence is not synonymous with personal injury caused by accident, and hence may not be covered by the Act, has been accepted by the Authority and by the Courts. Although such acceptance appears at first sight to run contrary to the intention of the legislation to abolish the negligence proceeding for personal injury, it illustrates yet again the difficulties involved in clearly defining the term 'accident' for the purposes of the Act.[114]

Misguided attempts to protect the conventional practice of medicine and the unfortunate distinction between accident and illness conspire to leave both doctor and patient in a vulnerable position. In this area, accident compensation decisions bear a striking resemblance to their counterparts in common law jurisdictions and only enlightened decision-making will alter this unsatisfactory situation. Effective cover will only be available when a wide interpretation is used and the distinction between accident and sickness is removed.

Of course, it is relatively simple - perhaps even tempting - to criticise innovative legal schemes. The status quo is comfortable, even although it may be the subject of complaint when it fails. Despite the obvious problems of the system of liability operating in most developed countries, there is security and reassurance in the old, and philosophical and practical doubts about the new. Compromisers seek some middle course hoping for the best of both worlds. Indeed, it is no exaggeration to say that the tort or delict system has, in many countries, succumbed to demands for change and that a kind of mixed system of liability applies in many jurisdictions already. This has the advantage of satisfying the defenders of the old and the visionaries of the new. But it must not be forgotten that the common law has changed primarily as the result of external pressures. It is not necessarily the case that the system itself is so structured as to make change simple, rather that the impetus for change often comes from pressure groups distressed by the sometimes long-term deprivation of individuals or groups. As liability has been extended, more groups have been included - for example children born damaged who sustained injury pre-birth, or as a result of pre-conception harm to their parents.[115] The type of action to be raised may have changed, as in the United Kingdom with the introduction of a strict liability system for vaccine damaged children.[116] However, not only do these schemes have their internal drawbacks, but many victims will still remain uncompensated.[117] In a welfare state, this may seem to be less problematic than in other communities, but this is only to beg the fundamental question of society's actual concern for the damaged, the weak and the vulnerable. Mere piecemeal pension-type payments may be entirely unsatisfactory, and the private law nature of the system ensures that rehabilitation need not be a priority.

The philosophy of the Woodhouse Report seems to reflect society's concern for its citizens, and to restate convincingly its responsibility for them. All systems have their drawbacks. Largely, however, they may be defined in terms of the extent to which they contain significant restrictions and limitations on eligibility. The more the system excludes, the less will be the satisfaction with the system itself. Woodhouse, unfortunately made the same fundamental error of introducing exclusions as have other less radical schemes. Universal inclusion would render disputes about eligibility, fault and causation obsolete - major difficulties for any pursuer in traditional systems, and surprisingly not entirely foreign to the accident compensation scheme.

Having said this, however, it is worth noting that criticism of the accident compensation scheme is relatively rare in New Zealand. It may be that this reflects a general satisfaction with the scheme, although the more cynical have reflected that:

> ...the economic investment in the program and

> the emotional commitment to it have turned accident compensation into something of a "hands off" issue. Many people, especially politicians, are acutely aware that to a certain extent New Zealand's international reputation is at stake when tampering with accident compensation.[118]

Whilst this might be accurate, it is also the case that the system - with all its flaws - does present a view of state as essentially benign and supportive. Moreover, its effect has not just been the somewhat negative one commented on by some tort lawyers. Whilst much of its impact may be symbolic, it has nonetheless ensured that many people who would otherwise not have received any compensation, are now in a position to obtain the help they need. There is scope for improvement, of course, but the improvements needed are practical rather than philosophical and in some ways, therefore, easier to achieve. A return to the fault based system is unlikely, and would in any event solve no problems. Furthermore, the fault based action reflects a particular view of compensation which would now seem to be - politically at least - obsolete in New Zealand. As Lloyd-Bostock says:

> The question of whether or not the law should provide compensation on the basis of fault ultimately comes down to value judgements about what kind of society we want to live in, and what principles and priorities are reflected in our lives.[119]

New Zealand has indeed made a brave commitment to a set of priorities which are not so readily identifiable in states which demand personal accountability as the primary means of allocating blame - which is essential to the fault based action - and force private funding of compensation despite the knowledge that many victims will not be helped by this process, and that new victims may be added to the list through the personal hardship of having to pay damages. It is to be hoped that smugness does not affect the accident compensation scheme - there is a way to go. Nonetheless the scheme's philosophy satisfies the moral intuitions of many and may, with detailed self-analysis and informed self-criticism, yet prove to be the bold, humane and truly comprehensive system which was intended.

For the patient, however, the major problems <u>are</u> structural, and depend less on the vagaries of extra-legal concerns than in other areas of concern. Where violation of autonomy forms the basis of a grievance, the system, by definition and interpretation, seems unsuited to the vindication of patients' rights, and to offer less chance of success even than negligence analysis. Certainly, the development of a meaningful doctrine of consent based on information disclosure and satisfying the patient's rights in medicine, seems to be unlikely and may indeed be ultimately impossible.

NOTES

1. Having only developed significantly in the last 50 years or so; c.f. Weir, T., A Casebook on Tort, (5th. Ed.), London, Sweet & Maxwell, 1983, at p. 267: 'It was barely fifty years ago that the tort of negligence was born, or synthesised, but it has thrived so mightily and grown so lusty that one could be forgiven for wondering whether there was room left for any other tort at all.'

2. For a discussion of the actual deterrent effect of the fault based action see, Brown, C., 'Deterrence and Accident Compensation Schemes', University of Western Ontario Law Review, 17 (1978-79), 111; for an excellent discussion of current and alternative systems of liability and their impact, see Atiyah, P.S., Accidents, Compensation and the Law, (3rd. Ed.), London, Weidenfeld and Nicolson, 1980 (reprinted 1984), at p. 593: 'There is no doubt that to some extent the tort system reflects the purposes of general deterrence.'.

3. c.f. Reparation by the Offender to the Victim in Scotland (Dunpark Committee) Cmnd 6802/1977.

4. Compensation for Personal Injury in New Zealand, Report of the Royal Commission of Inquiry, Dec. 1967.

5. Woodhouse Report, p.11.

6. Woodhouse Report p.39, para 55.

7. p.20, para 5.

8. p.19, para 1.

9. 'Community Responsibility for Accident Victims: Changes in the New Zealand welfare state' [1979] Social Services Review, Bryn Mawr College, University of Chicago, at p. 246. Quoted in Klar, L.N., 'New Zealand's Accident Compensation Scheme: A Tort Lawyer's Perspective' (1983) 33 University of Toronto Law J. 80.

10. for discussion of remedies, see Walker, D.M., The Law of Delict in Scotland, (2nd Ed., revised), Edinburgh, W. Green & Son Ltd., 1981, particularly ch. 14; Street on Torts, (7th. Ed.), London, Butterworths, 1983, ch.11; Rogers, W.V.H., Winfield and Jolowicz on Tort, (12th. Ed.), London, Sweet & Maxwell, 1984, ch. 23.

11. Palmer, G.W.R., 'Compensation for Personal Injury: A Requiem for the Common Law in New Zealand' 21 American Journal of Comparative Law (1973) 1.

12. p.47, para 48.

13. p.50, para 88.

14. p.48, para 82.

15. p.33, para 39.

16. p.50, para 87.

17. Palmer, G.W.R., <u>Compensation for Incapacity</u>, Wellington, O.U.P., 1979, at p. 23.

18. Cmnd.7054/1978.

19. c.f. Klar, <u>loc.cit</u>.

20. Palmer, <u>op.cit</u>. at p 26.

21. for discussion, see Jandoo, R.S. and Harland W.A., 'Legally Aided Blackmail', <u>134 New Law Journal</u>, 402 (1984)

22. Palmer, <u>op.cit.</u> at p. 25.

23. <u>id.</u>

24. Accident Compensation Act 1982.

25. Accident Compensation Act 1982 s.2.

26. p.113, para 289.

27. p. 39, para 55.

28. <u>Compensation and Rehabilitation in Australia</u>, Report of the National Committee of Inquiry, 1974.

29. Cripps, C.R., 'Medical Practitioners' Liability for Personal Injury Caused by Negligence' [1978] <u>N.Z.L.J</u>. 83, at p. 84.

30. for discussion, see Mahoney, R., 'Informed Consent and Breach of the Medical Contract to Achieve a Particular Result: Opportunities for New Zealand's Latent Personal Injuries Litigators to Peek Out of the Accident Compensation Closet', <u>6</u> <u>Otago Law Review</u> 103 (1985).

31. Palmer, G.W.R., 'Accident Compensation in New

Zealand: The First Two Years' 25 American Journal of Comparative Law (1977) 1, at p. 9.

32. [1972] All E.R. 145.

33. Medical Information Bulletin, No. 13, Oct. 1981.

34. Review No. 74/R0298.

35. Review No. 75/R0461.

36. c.f. Mahoney, loc.cit.

37. supra cit.

38. at p. 181.

39. Mr. Justice Woodhouse noted, for example, that '...the Accident Compensation scheme, in the five years of its operation to 1979, has been able to make savings for reserves of no less than $172.9 million.' Kennedy Elliott Memorial Lecture reproduced in [1979] N.Z.L.J. 395.

40. Klar, loc.cit., at p. 87.

41. see, for example, Roe v. Ministry of Health [1954] 2 Q.B. 66.; Lim Poh Choo v. Camden and Islington A.H.A. [1979] 1 All E.R. 332.

42. see, Sandford, K.L., 'Personal Injury by Accident' [1980] N.Z.L.J. 29, at p. 30 'The percentage of claims declined is less than 4 percent, and in a proportion of those the reason for declinature is some matter irrelevant to the present subject (e.g. that the accident happened before 1 April 1974).'

43. Pearson Commission, para 1326

44. Black, Tony, 'What is Personal Injury by

Accident?' [1979] N.Z.L.J. 465, at p. 42.

45. Palmer, G.W.R., loc.cit. at p. 39.

46. Appeal Dec. No. 9 (1976).

47. Accident Compensation Act 1982.

48. loc.cit.

49. Lloyd-Bostock, S., 'Common Sense Morality and Accident Compensation' [1980] Insurance Law Journal 331.

50. Appeal Dec. No. 33 (1977).

51. loc.cit., at p. 80.

52. Klar, loc.cit., at p. 91.

53. loc.cit., at p.86.

54. For further discussion, see Mahoney, loc.cit.

55. Accident Compensation Act 1982 s. 2(1) a) ii); for discussion see Hughes, J., 'Accident Compensation and Childbirth' [1981] N.Z.L.J. 79, at p. 85: 'The long pedigree of the word "misadventure" in cases involving medical negligence should be placed in its proper perspective: that of a system primarily concerned with establishing the cause of accidents rather than the nature of injury.'

56. for discussion, see chapter 4, supra.

57. see chapter 4, supra.

58. Gamble, A.J., 'Professional Liability', in McLean, S.A.M., (ed), Legal Issues in Medicine, Aldershot, Gower, 1981, at p. 89.

59. para 1326, where it is noted that the success

rate in all personal injury claims is 86%, whereas it is 30-40% in medical cases.

60. which the Pearson Commission felt to be the most common type of harm resulting from medical intervention.

61. for further discussion, see chapters 3,4 and 6 supra.

62. c.f. Lim Poh Choo, supra cit., for further discussion, see Brazier, M., Medicine, Patients and the Law, Harmondsworth, Penguin, 1987, chapter 6.

63. Blair, A.P., Accident Compensation in New Zealand, Wellington, Butterworths, 1978, at p. 9: '...the Act is not controlled by restitution principles, and in fact does not purport to provide full compensation, but rather attempts to minimise the accident victim's loss by providing both monetary and other practical help which will aid the claimant not only as regards the immediate difficulties caused by the accident, but also as regards the long term effects.'

64. op.cit., at p. 43.

65. id.

66. Medical Information Bulletin No. 14 (Wellington, Accident Compensation Corporation) October 1981.

67. Application for Review 74/R00186 (1974), at p. 3.

68. Review No. 74/R00408 (1974) '...in the absence

of original injury by accident I cannot accept that the development of an embolus can itself be regarded as an accident any more than many other physiological changes and reactions within the body.'

69. see pp.441-43 *infra*

70. for discussion, see chapter 4, *supra.*

71. for discussion, see chapter 4, *supra*

72. *Appeal Decision No. 9* (1976) at p. 6.

73. *Review No. 74/R00432* (1974)

74. *Review No. 74/R00408* (1974), at p. 3.

75. *id.*

76. This bears a striking resemblance to the statistical calculation of risk described in chapter 5, *supra.*

77. see chapters 4, 5 and 6, *supra.*

78. and thus no incentive to develop real dialogue and vindicate the rights which it has been claimed the patient has in the medical event.

79. *Review No. 77/R1352*, at p. 7

80. Blair, *op.cit.*, at p. 43.

81. see chapter 4, *supra.*

82. Palmer, *loc.cit.*, at p. 38.

83. for discussion, see chapter 3, *supra.*: for comment on the role of assault and battery under the accident compensation scheme, see Vennell, M., 'Some Kiwi Kite-Flying' [1975] *N.Z.L.J.* 254, at p. 256: 'The tort actions in assault and

battery clearly would be the ones in which it would be easiest to separate the damaging event from the damage so as to see that more than one head of damage had flowed from the damaging event. Since s. 5 of the Act only supplants the common law claim for damages flowing from personal injuries, the cause of action giving rise to a claim in damages remains intact so long as a particular kind of damages, namely, that resulting from personal injury, is not included in the claim.'

84. see chapter 6, _supra._

85. see chapter 5, _supra._

86. see chapters 4 and 6, _supra._

87. _Review No 77/R1352_ (1977) at pp. 7-8.

88. i.e. the facts speak for themselves.

89. e.g. _Mahon_ v. _Osborne_ [1939] 2 K.B. 14.; _Cassidy_ v. _Ministry of Health_ [1951] 2 Q.B. 66; Kilner Brown, J. in _Ashcroft_ v. _Mersey Regional Health Authority_ [1983] 2 All E.R. 245, at p. 246: 'Where an injury is caused which should never have been caused, common sense and natural justice indicate that some degree of compensation ought to be paid by someone.'; _Grant_ v. _Australian Knitting Mills_ [1936] A.C. 85.

90. _op.cit_, at p. 33.

91. see chapter 6, _supra._

92. op.cit.

93. loc.cit. at p. 85.

94. for discussion, see Walker, op.cit.; Winfield and Jolowicz on Tort, op.cit.; Street on Torts, op.cit.;

95. Lim Poh Choo, supra cit.

96. op.cit., at p. 39.

97. loc.cit., at p. 86.

98. loc.cit. at p. 88.

99. for further discussion, see chapter 4, supra.

100. Osborne, P.H., 'Informed Consent to Medical Treatment and the Accident Compensation Act 1972' [1979] N.Z.L.J. 198, at p. 198.

101. for discussion, see chapter 4, supra.

102. Palmer, loc.cit., at p. 38.

103. [1981] N.Z.A.C.R. 9

104. [1954] 2 Q.B. 66

105. at p. 13

106. id.

107. loc.cit. at p. 39.

108. id.

109. loc.cit.

110. c.f. Review No 76/R1788 (1976) at p. 4.: 'The argument that interference with the natural course of things is enough to constitute internal events of this kind "accidents" is not, in my view, sound. Where such interference is carried out by persons of professional status

and at the request of the patient, and where the outcome is a reasonably contemplated risk of treatment the concept of accident is quite out of place.'

111. Review No 75/R0236 (1975), at p. 2.

112. see chapter 4, supra.

113. see chapter 3, supra.

114. 'Medical Practitioners Liability for Personal Injury Caused by Negligence' [1978] N.Z.L.J. 83, at p. 83.

115. c.f. Congenital Disabilities (Civil Liability) Act 1976 (England and Wales); Scottish Law Commission, Liability for Antenatal Injury, Cmnd. 537/1973.

116. Vaccine Damage Payments Act 1979.

117. c.f. McLean, S.A.M., 'Compensation and Medical Injury' SCOLAG Bul. (1981) 343.

118. Klar, loc.cit., at p. 101.

119. loc.cit., at p. 345.

# THE SPECIAL GROUPS

## CHAPTER 8

It has been claimed that the right to consent to medical treatment is a right of considerable importance for the would-be autonomous human being.[1] That the law at present seems, in most if not all jurisdictions, to be ill-equipped to handle this right effectively or sensitively is a subject for concern. This is the case, not merely because there is something inherently valuable in the abstract about the claim to self-determination in medicine, but also because only direct access to this right protects the citizen from his or her vulnerability to the power of medicine, and stimulates his or her capacity to challenge professional paternalism which, however well intentioned, can be, and often is, a face-on threat to autonomy.

However, there are some groups of individuals within communities for whom the significance of the right may be either downgraded or denied. It has, for example, been a most important aspect of the right as formulated here, that its primary significance lies in its capacity to facilitate self-determination, or perhaps to express self-determination in a clear and uncompromising way and in a manner consistent with the rights of the individual to liberty and privacy as aspects of that right. Thus, it seems clear, the capacity to act in a self-determining manner is central to the right as described. In so far as this goes, however, it is obvious that describing the right in this way leaves one open to the charge that it would therefore have a limited application. Those groups whose autonomy is in doubt could, in these terms, find themselves clearly outside the scope of the right and denied the protection which it is claimed it can offer.

If this were, therefore, an inevitable conclusion, then clearly, both practically and theoretically, it could have serious implications for the right itself. At a practical level it would, unless legal or social change were instituted, automatically exclude groups such as children, the mentally ill and the mentally handicapped, and deny to them the respect and protection which being within the ambit of the right can provide. At a theoretical level, it could challenge the very claim that there is a fundamental right to participation in therapeutic choice, firmly based in information disclosure, and demanding that disclosure whether or not is is actively sought in individual circumstances. At best, therefore, the right becomes merely something which is of interest to certain privileged groups, and at worst it loses the universality which is said to characterise a human right and distinguish it from a mere interest. If this position is adopted, then one might well question the importance of information disclosure, since it appears to be relevant only to certain groups in the community. Moreover, it might be further noted that these groups probably equate fairly closely to those with whom the doctor would most likely share information in any event, since they are the rational, sensible and intelligent members of the community who could be trusted, even perhaps by paternalists, to take the 'right' decision and not overreact.

So, it could be concluded, detailed discussion of the right to information disclosure and the value of the resulting therapeutic partnership, whilst perhaps of academic interest, is, in meaningful terms, a redundant and unnecessary exercise, since ultimately all that it amounts to is a reaffirmation of the way in which a 'good' doctor would in any event treat a 'good' patient. For the rest, paternalism is essential - a necessary evil, perhaps, but necessary nonetheless. To draw such a conclusion, however, would be seriously to misunderstand the value of the application of the right, and further to make seriously erroneous deductions from the state of current legal and social thinking. Moreover, to adhere to this position is to place an intimidating amount of power in the hands of one professional group. Even a right based on capacity for, or interest in, making autonomous choices need not be so limited as to make blanket exclusions of such a sweeping nature as this.

In considering the special position of these groups, therefore, it will be argued that it is not the case that their status <u>in se</u> denies them access to information disclosure and decision-making, although this may be the outcome in some limited circumstances. Rather, it will be claimed, it is clear that current laws do countenance and validate autonomy-enhancing behaviour by these groups, and it will further be shown that recognition of the importance of the right may lead to expansion rather than contraction of the numbers of these currently privileged individuals.

The blanket assumption that a right firmly based on autonomy has no relevance for these groups is based on a number of misconceptions. The first of these is that the setting of a legal barrier, or the classification of mental condition, necessarily justifies differential treatment, and the second is the assumption that the law invests its created barriers with an almost mystical force which demands that they are always applied without analysis.

In any event the law is somewhat complex in regard to those who are regarded as _incapax._[2] As Walker[3] notes:

> The whole private law is stated by reference to the individual who is bodily and mentally _capax_, and every person is presumed _capax_ .... If not under curatory an _incapacax_ may sue and be sued himself, his capacity and responsibility in relation to the matter in issue being a question of fact. It is always a question of fact whether the alleged _incapax_ did or did not , at the material time, have the mental capacity to appreciate the legal force of the transaction he was entering into.....'[4]

The groups who are routinely regarded as incapax are those with whom this section is predominantly concerned. They will, however, be so defined by reference to a general categorisation which may or may not be definitive of their legal standing. In other words, boundaries may be created which practically describe groups, but it need not be assumed that their force is overwhelming when deciding whether or not the decision of an individual can or should be binding.

The law routinely sets barriers, often acknowledging their essential arbritariness, and certainly noting that their applicability may change with changing circumstances and social mores.[5] However, where guidelines do seem to be required (for example the legal statement of the age at which a child may be criminally responsible[6]) their purpose may or may not be to raise an irrebuttable presumption. In the case of the above example, the presumption is irrebuttable, because of the potentially unacceptable consequences of individual and subjective judicial or prosecutorial decision-making about the imponderable, and because of the consequences of a finding of responsibility. Other legal barriers, however are designed to establish what should be the case. For example, the presumption that a child under the age of 16 years cannot legally consent to intercourse is more of a device to avoid exploitation and to express what society thinks behaviour should be, than it is a presumption of the same sort as that made in respect of criminal responsibility. Absolute certainty in the application of the law is achieved by the former, and relative certainty by the latter.

However, whether the magical age of majority (the age at which a person becomes fully responsible for all of his or her behaviour and is therefore also accorded the full panoply of civil rights), is fixed at 16 or at 18 or even at 21, there is little doubt that contemporary law seems reluctant to make a blanket assumption that below this age no rights (and equally no responsibilities) can be attributed.[7] However, it is clear that their very existence presents some difficulties for those who would wish to argue for an extensively applicable right to consent to medical treatment or to withhold that consent. If they are narrowly interpreted, then the implication logically seems to be that those who have not reached the barrier age lack the <u>legal</u> capacity to enter into certain agreements, or to choose a sexual partner, for example. They are thus effectively denied the status of autonomy, and by definitiion could not therefore be <u>legally</u> able to make autonomous choices about health care. If this interpretation is applied, all children will be denied the protection offered by the right because they are not legally autonomous. Decisions will be taken by other authorised people on their behalf and the child's own decision will be given no weight.

However, the right to consent to medical treatment is not necessarily dependent on legal definition of capacity, nor is there any imperative that artificially created barriers must be applied in a rigid and inflexible manner. Indeed, it has been claimed _supra_ that the right to consent is not routinely applied by courts even in respect of those whose legal capacity is not in any doubt. In other words, the right itself cannot simply be defeated by the fact that the law fails to acknowledge it in all circumstances where it has value and merit. The mere existence of legal hurdles (in the form, for example, of temporary legal disability or decision making practices) does not defeat the right, if indeed the right has an intrinsic worth.

Even those most closely wedded to medical paternalism would scarcely adopt such a position, for to do so would render _all_ of us vulnerable to disinformation, misinformation or no information at all. It can safely be argued, therefore, that there is a significance to be attached to a therapeutic alliance, even where legal systems are reluctant to give outright support to it, and even where those legal systems limit its applicability.

Equally, the mere diagnosis of mental illness need not absolutely deny autonomy to the affected individual, and indeed the law routinely makes no such assumption.[8] This can be shown by two methods. On the one hand, the law has clarified the rights of the mentally ill to give or withhold consent in certain circumstances,[9] and on the other the law will not inevitably accept psychiatric diagnosis.[10] The significance of this latter point is most clearly observed in the criminal law, which permits legal responsibility for otherwise criminal activity to be elided on evidence of mental disorder.[11] However, not all mental disorders have this effect,[12] not all psychiatric assessment of mental condition is accepted, and the court is free to ignore even uncontested medical evidence of mental disorder and substitute its own assessment of the state of mind (and legal responsibility) of the accused.[13] The law is not, therefore, entirely unused to assessing medical categorisation and, sometimes, finding it wanting as a yardstick for the attribution or denial of civil or human rights or responsibilities. There is, therefore, no blanket assumption to be made merely as a result of the fact of diagnosis, and this affects the right and the capacity of the individual to claim autonomy, accept responsibility and make self-determining choices.

Before considering these groups in more detail, therefore, at least one conclusion can be drawn. The law is <u>already</u> prepared to look beyond the apparent certainties of age or mental condition. As Lord Scarman made clear in the case of <u>Gillick</u>[14] the law must be prepared to take account of changing attitudes even when faced with apparent legal truisms.[15] Given the extent to which the law (through judicial discretion and decision-making) has altered the face of rights and their applicability,[16] it would be difficult to argue that they cannot, or should not, take account both of changing circumstances and of forceful theoretical arguments which accord with a satisfactory moral position. It can legitimately be argued, therefore, that the mere appearance of blanket denial of autonomy in certain groups neither reflects <u>in fact</u> the current legal position nor need it affect the claim that the right to consent to medical treatment is a right of considerable sigificance, whose application should not be unthinkingly or needlessly restricted. Indeed, consideration of those groups for whom the application of the right may seem problematic, will, rather than denying the value and applicability of the right, highlight even more clearly the inherent importance of its vindication.

## Children and Medical Treatment

The position of children in law can perhaps best be described as confused. This confusion arises substantially from the tradition of parental control and custody over children.[17] Where parent and child confilict, it is tempting to assume value in the adult perspective, and in any event, since adults are charged with the responsibility for ensuring the well-being of children, and for managing their affairs,[18] it seems logical to attribute decision-making powers to them.

Only in the most extreme cases, for example in cases of child abuse, will parents lose their control over children. As Walker puts it:

> Parental rights and powers are of two kinds, that of guiding and directing the persons of children under full age, and that of legal administration, of managing their property and legal business or advising thereon.[19]

In Scots Law, therefore, the parental role is either, in effect, one of control or one of guidance. Walker further notes that the extent to which the parental role is either all-powerful or merely advisory depends on the age of the child.

> So long as the child is a pupil, the father had at common law, and now each parent has, the right of custody, and the power and authority to regulate the child's upbringing and discipline and govern its person; this power is diminished but not ended when the pupil child becomes minor, and terminates when the minor child becomes major.[20]

English law too, although based in a different tradition and not recognising concepts of minority in precisely the same way as Scots Law,[21] nonetheless has long acknowledged the limitations on parental authority. As Lord Denning, for example, noted:

> .....the legal right of a parent to the custody of a child ends at the eighteenth birthday and even up till then, it is a dwindling right which the courts will hesitate to enforce against the wishes of the child, the older he is. It starts with a

> right of control and ends with little more than advice.[22]

Since it is the custody right which gives parents the authority to make decisions on behalf of, or in the best interests of, the child, then there is considerable significance in the view that this right is not only not absolute, but is also diminishing. That it is not absolute is shown by the fact that courts can and will step in where parents are thought to be abusing their position.[23] That it is dwindling may be shown where courts place weight on the views of a child, in matters, for example, of custody after divorce.[24]

However, the fact of parental authority, however much it dwindles even when someone is under age, does mean that the authority to be given to the views of children is often preliminarily subject to scrutiny, not in terms of children's rights but rather in terms of parents' rights.[25] In other words, the current legal assumption may be expressed in such a way as to imply that the choice of the parent, so long as it is not overtly against the best interests of the child, is the choice which has force. It is necessary, therefore, to consider at this stage the extent to which parents <u>do</u> have rights over their children with particular reference to medical matters. Although it may be morality which attributes theoretical status to individuals, the response of the law to demands for, e.g. autonomy, has a primary significance in the actual extent to which rights can be vindicated.

It has already been noted that the fundamental problem in the attribution of rights to children is the fact that autonomy based rights are presumed to require actual, as opposed to potential, capacity for autonomy. The attribution of many fundamental rights to adults is based on their capacity for autonomy - hence the purported justification for the exclusion of the mentally ill or children, for example. The restrictions placed on children reflect a recognition of the fact that they may not yet have achieved that level of maturity and understanding of consequences enabling them to make decisions which will be upheld whether or not they seem to the outsider to be the best decisions. It is this dubiety which routinely invokes the use of parental authority as a proxy decision-making tool (this applies equally to those who stand <u>in loco parentis</u> to the child).

However, the law is no longer - if, indeed, it ever was - prepared to draw such a clear-cut line as this. This is not to deny the role of the parent or guardian, but rather to define it more clearly, and to recognise the immense variety of attributes which both children and their legal guardians may have. Moreover, it also serves to recognise the fact that children may have certain rights which can be vindicated even where parental views conflict with them. As Lord Scarman said in <u>Gillick</u>:[26]

> Parental rights clearly do exist, and they do not wholly disappear until the age of majority. Parental rights relate to both the person and the property of the child: custody, care and control of the person and guardianship of the property of the child. But the common law has never treated such rights as sovereign or beyond review and control. Nor has our law ever treated the child as other than a person with capacities and rights recognised by law.'[27] (emphasis added)

Much of the case law in this respect has grown up around the issue of custody after divorce. In this most important matter of where the child should live and with which parent, courts have been increasingly prepared to give weight to the view of the under-age child. Respect is given to the wishes of the child in this issue, particularly where the child is older and is thought to be capable of understanding the implications both of the situation and of the choice. It is self-evident that in such situations the views of the child will not equate with the view of one of its parents, but they nonethless will be given priority or at least considerable weight. For example, in the case of Gover v. Gover,[28] the court indicated that it would be unrealistic - even wrong - not to give 'very great and usually decisive'[29] weight to the views of the child. There is no reason why a similar view could not be taken in respect of medical treatment, even despite a somewhat unhappy ambivalence on the question of children's rights and parental rights in this area.

Different approaches to rights may be taken by states and their legal systems, and to some extent these differences stem from differing legal, social and political traditions. Countries with a written Bill of Rights have a relatively clear framework within which to operate, whilst those - like the United Kingdom - without such a formal statement of rights may tend to a more ad hoc type of decision-making, based on factors which relate as much to entrenched social attitudes, or even matters of current concern, as they do to issues of human rights per se. Thus, as has been noted,[30] it is relatively unusual for British courts to debate issues in the clear language of human rights, whereas in the United States such language is relatively commonplace.

The position in the United States does not, of course, inevitably guarantee consistency of approach either between or among states, since interpretation of constitutionally guaranteed rights may vary.[31] However, the existence of a rights-dominated constitution can be said to provide a backcloth against which issues can be tested. Equally, challenges in courts are relatively more common in the United States so that courts have had the opportunity of testing and refining their approach to certain issues, for example in relation to the question of children's rights in general, and in respect of health care matters in particular. Thus, it has been held that children need not be subject to a parental refusal of treatment,[32] and that, over parental objection, cosmetic surgery can proceed even where known to be risky (because the child's right to a normal development would be enhanced if the surgery were successful).[33] Moreover, despite theoretical prohibitions on the use of young children as organ donors or in experimental situations, a young child's wish to donate bone marrow to a sibling has been upheld because of the possible distress to the child should the sibling die.[34]

In the United States, courts, in deciding on health care matters, have tended to make certain assumptions which predispose them to view the issues under consideration from a particular perspective. Most states, therefore, have tended to view the problems arising in disputes over health care not from the perspective of children's rights pure and simple, but also by taking into consideration other - and sometimes competing - rights, such as the right to family integrity.[35] What is at stake, then, is primarily the power of the parent over the child - in other words, parental rights - and the extent to which the state may interfere in this classical privacy right.[36] That the resulting decision may be couched in terms of children's rights can be misleading. Nonetheless, the American child can, at least, appeal to the language of rights in seeking to vindicate and obtain authority for his or her own views.

Assessment of the extent to which their British counterparts may validly claim to have rights in health care matters is perhaps more subtle, and is certainly confused by a number of court decisions.[37] Bearing in mind the fundamental question as to whether or not courts <u>do</u> give rights to children in health care decisions, there are two main scenarios which can be postulated to elucidate the response of the courts. Since Scottish courts have not confronted these issues directly, the main source of information will be the approach adopted by the English judiciary. It may, however, be argued that the outcome in the cases under consideration is likely to have been the same since the Scottish division into pupillarity and minority is not immediately relevant to them, and the matters of concern would apply in each jurisdiction. These scenarios are as follows: first, where parental choice conflicts either with the views of the child and/or with the state's interest in health care provision, and second, where the child's view cannot be ascertained but there remains a potential conflict between parental decisions and the interests of the state (as represented by the judiciary). Both of these encompass situations already considered by British courts.

Despite earlier doubts as to whether or not the provision of contraceptive advice and treatment is indeed an aspect of health care, the court in the <u>Gillick</u>[38] case were confident that it was. The question to be answered, therefore, was - at least in part - the extent to which the child was entitled to make personal, and authoritative, decisions about using contraception without the parent necessarily being notified or involved in the decision-making process.

At the first hearing of the case,[39] Mr. Justice Woolf was in no doubt that there was here no conflict of rights. Parents, in his view, had responsibilities rather than rights, and the resolution of the problem depended on the status accorded to the individual child.[40]

Scots law adopts a number of distinctions which predict the extent to which the behaviour of the child will be given authority. Although a full discussion of this is not necessary here, there are characteristics of this distinction which are relevant to the current discussion. The most critical difference between Scots and English law is the division drawn by Scots law of the status of childhood into pupillarity and minority. Its effect is to offer some assistance in the assessment of capacity to make certain decisions, even although the question of children's rights in health care has not been directly confronted by a Scottish Court.

It can safely be assumed, however, that - where the child is a pupil - it will be necessary that decisions are taken on behalf of, and in the best interests of, that child by other. The position of the pupil child is as follows:

> Pupils, that is boys aged under fourteen and girls aged under twelve, the traditional age of presumed puberty, have, for reasons of

> their natural incapacity, strictly limited legal personality...[41]

Given this, '[a] pupil must...have a parent or other person to act as his tutor and administrator-in-law.' [42] It can, therefore, safely be deduced that decisions in respect of therapy must, in the case of pupils, be taken by authorised others. This is, of course, subject to the overriding authority of the court to scrutinise, modify or overrule decisions which seem to conflict with the 'best interests of the child'.

The minor child, however, is in a different situation and has:

> ...legal personality and considerable though limited legal capacity and powers....He is capable of entering into legal transactions, though requiring the protection of the law by reason of his inferior judgement or discretion.[43]

The minor child in Scots law, therefore, will be given some authority to make decisions which have significance - a limited capacity to exercise autonomy is thereby recognised.

From the status traditionally accorded to children in Scots law can be inferred the likely approach of the courts to disputes concerning therapeutic choice. Where the child is a pupil, the decision of an authorised adult will be validated subject to that decision being in the best interests of the child.[44] In the case of a minor child, subject to certain limitations designed to afford a degree of protection, the child will have decisions respected in recognition of developing capacity and maturity. As has been said[45]:

> Whereas much of the law on the legal capacity of minors is concerned with the question whether they can make themselves liable, the law on consent by minors to medical treatment is concerned with the question whether they can absolve other people from liability.[46]

At present, S.H.H.D. Circular DS (79)2 seems to adopt the view that the age of consent to medical treatment is sixteen, but there are serious reasons, already expressed, for doubting the validity of this view in the case of the mature minor child. In addition, as the Scottish Law Commission's Consultative Memorandum [47] further notes:

> Medical practice does not make law. If 16 is the age of consent to medical treatment in Scots law then this must rest on the common law or on statute. It cannot rest on the common law because the age of 16 has no special significance at common law. It does not rest on statute because there is no statutory provision on this subject in Scotland. There appears, in short, to be no legal foundation for the widespread view that 16 is the age of consent to medical treatment in Scotland. The question is governed by the common law and at common law the only relevant age is the age of minority - 12 for a girl and 14 for a boy.[48]

Since in contemporary society the perceived distinctions between males and females are less routinely appealed to, it seems likely that all children, whatever their sex, would be treated in a similar manner over the age of twelve. In any event, the Memorandum continues:

> ...it is by no means certain that a child below the ages of 12 or 14 could not give consent, at least to certain types of medical treatment, which would provide an effective defence to a prosecution for assault or a civil claim for damages for assault. Much would depend on the age and understanding of the child and on the nature of the treatment.[49]

The capacity of a child to consent to medical treatment was largely unexplored in English law beyond the provisions of the Family Law Reform Act 1969, s.8 of which states that 'the consent of a minor who has attained the age of sixteen years to any surgical, medical or dental treatment, which, in the absence of consent, would constitute a trespass to his person, shall be as effective as it would be if he were of full age.' However, s.8(3) of the same Act makes it clear that the Act does not affect the validity of any consent which would have been effective had the legislation not been passed. The court therefore was at liberty to interpret the legislation, as it in fact did, as implying that the consent of someone <u>under</u> sixteen could also be effective.[50] The decision as to the validity of any purported consent would, the House of Lords declared, rest on the maturity of the child and her capacity to understand the implications of her choice.[51] The child who is thought to be sufficiently mature is therefore given the status of autonomy, even although the rules may at first suggest that capacity depends on age and not maturity. In the United States also it has been held to be unconstitutional to make a blanket requirement of parental consent based solely on the fact that the child is under age.[52]

The position in these jurisdictions therefore would seem to be that the 'mature' child has the right to make free choices in health care matters - choices which will be up upheld by the courts. However, the right to make these choices would seem to rest also on the nature of what is being consented to, and so cannot be taken necessarily to be generally applicable even to the 'mature' child. In the United States, on the other hand, although '.....recognition of independent rights for children is a recent development .....'[53] nonetheless:

> .....the scope and character of those rights has been a focus of scholarly attention. Children's rights have been found to include due process, privacy, and first amendment rights. Additionally, the child has an interest in family integrity and in protection of personal autonomy and individual choice.[54]

British courts seem to be slightly less theoretically developed in this area. In the <u>Gillick</u> case the ultimate value was apparently given to the rights of children to privacy (of a sort), and the decision seems to lend some credibility to the assertion that children do have rights in health care matters which are distinguishable from the parents' decision as to what is in the best interests of the child. The nature and extent of these rights remains relatively unclear, although Lord Fraser at least was in no doubt as to their purpose. In his view:

> .....parental rights to control a child do not exist for the benefit of the parent. They exist for the benefit of the child and they are justified only in so far as they enable the parent to perform his duties towards the child, and towards other children in the family.[55]

This statement seems to provide some flexibility in the assessment of the extent to which competing, or apparently competing, parental views can affect the choice of a given child. However, merely to conclude that parental rights diminish with the child's age, or that they exist for the benefit of the child, indicates something about parental rights, but very little about the rights of children. If the effect of judgements of this sort is to be to give children certain autonomy rights, then the child's statement of preference (assuming any other criteria have been met) would be sufficient to validate the action to which they have consented, or to support their refusal. This, however is not necessarily the case, since the validity of the decision may also have to run the gamut of a different set of criteria - namely, the views of the court.

On the one hand, courts have been prepared to countenance certain levels of independence for children or at least for the older child. As Lord Fraser said in Gillick:

> It is, in my view, contrary to the ordinary experience of mankind, at least in Western Europe in the present century, to say that a child or young person remains in fact under the complete control of his parents until he attains the definite age of majority .... and that on attaining that age he suddenly acquires independence.[56]

Nonetheless, courts will not in fact merely accept the view of a child even where parental views are deemed to have no value or relevance.

On the contrary, it can be said that courts will uphold the views of the child most commonly where, although they conflict with parental views, they concur with the view of the court as to what is 'in the best interests of the child'. What, therefore, even the Gillick[57] judgement may amount to is not so much a statement of rights for children in health care, but rather evidence of the fact that the judiciary were of the view that the interests of the child can sometimes be best served by permitting her access to contraception, and by encouraging or facilitating that access, even without reference to parental views, in circumstances where it is clear that the alternative is the risk of unwanted pregnancy. Courts, therefore, are somewhat loath to commit themselves to an outright championing of children's rights without first evaluating the impact of the child's decision and then pronouncing on its quality. This ambivalence reflects both confusion as to the applicability of the concept of rights, and the competition between on the one hand the value of allowing a child free reign and on the other the responsibility of the court to have the welfare of the child as its paramount consideration. Often, therefore, subjective judicial values are imported to replace those of the parent or the child.

One further matter can usefully be considered under this heading - a matter which testifies to the accuracy of the foregoing section and demonstrates clearly the ambivalence of the judiciary. Whether couched in terms of family integrity or in terms of the responsibilities of custody, developed jurisprudence traditionally pays respect to parental powers. Although these powers may be removed, there is generally a presumption that parents do and will act in their child's best interests - not merely physical but also moral, and some might say, spiritual. Careful protection is given, for example, to the rights of parents to choose their children's religious upbringing[58] - a choice which may not be value free in medical matters. Thus, parental rights in this area will be upheld <u>unless</u> their decision, and its implications, conflict with the view of others (notably the judiciary) as to what is in the child's best interests.[59] Parental refusal, on behalf of their children, of life-preserving medical treatment on religious grounds is now routinely overridden.[60] but the question remains, if parents have the right to make religious choices, on what grounds do they become defeasible (even, it should be noted where the child agrees with the parent)?

On the one hand, it could be said that the child has a right to life which in this situation implies a right to treatment, and it must always be 'in the best interests of the child' that this right is upheld. Whether or not this right is always upheld by the law will be considered later.[61] It could also be argued that, in the case of the 'mature' child, whilst an affirmative choice would probably be respected by the court, a negative choice defeats the presumption of maturity and therefore places the onus back on the court to safeguard the potential autonomy of the child in the face of parental or individual irresponsibility. Whichever is the correct interpretation, and it seems in the light of recent decisions more likely to be the latter than the former, it represents in no way a recognition of children's rights as such, but merely indicates that where the child behaves in accordance either with the views of its parents, or the views of the court, that choice will be upheld. The attitude of British courts, therefore seems to be at best ambivalent to the question of children's rights.

Of course, it is possible to argue that children <u>do</u> have rights, but that decisions are taken for them in order that they may ultimately be able to do so for themselves. In line with this view, children should have their fundamental rights protected so that they can reach maturity and then make their own choices. If this is the case, then the age of the child is irrelevant - what matters is that the child should be permitted to reach the age at which people are free to take their own decisions, however irrational they may appear to others. Thus, respect for the most important of all rights - the right to life - would become a prerequisite of this approach. Although children (particularly the very young) have no way of expressing a preference for life over death, the law is entitled to assume it, either because it enhances the child's opportunity of choosing for him or herself in the future, or because it must always be 'in the best interests of the child' to be alive rather than dead. Indeed, in actions for 'wrongful life',[62] which are rejected by British courts,[63] the courts have made it clear that it can never be worse to be alive than dead.[64] Thus, apparently uncontentiously, the law must at least in this situation attribute rights to children, whatever the views of their parents. But is this the reality?

British courts have recently taken two decisions which, although at first sight in conflict with each other, in fact display similar characteristics and which can serve as illustrations of the second postulated scenario. In the case of R v Arthur,[65] a doctor - with parental consent and authority - failed to operate to remove an intestinal blockage in a Down's Syndrome child. Without the surgery, the child would inevitably die and all parties were in agreement that this was the appropriate outcome (except, of course, the child). The doctor instructed that the child should receive nursing care only, and in due course, he died. At the subsequent trial of the doctor for murder (subsequently reduced to attempted murder) the court was apparently impressed by a number of arguments, not least of which was that the parents had cooperated in the taking of the decision, and agreed with it. In view of the earlier discussion of the courts' attitude to parental refusal of life-saving therapy this decision seems somewhat strange, not to say paradoxical. If rights are attributed to children, then this case seems to suggest that they are not attributed without differentiation. In fact, of course, both judge and jury were reluctant to hold the doctor criminally responsible for his behaviour in the exercise of his profession,[66] and in any event they sympathised with the views of the parents - quite a different situation from that where they disagree, but nonetheless very little to do with children's rights.

The second case referred to above seems at first sight to contradict the <u>Arthur</u> decision. In <u>Re B (a minor)</u>[67] the court, in the face of medical and parental objections, <u>did</u> authorise the removal of a similar intestinal blockage in a Down's Syndrome child, and apparently vindicated the child's right to life. However, on closer examination, the court was consideraby more ambivalent than this. This child was saved because her 'quality of life' after sugery would not be unsupportable - not because she had a right to life. A further example of the overriding of parental wishes can be found in the case of <u>Re D (a minor)</u>[68] in which case, having asserted the fundamental right of the citizen to reproduce,[69] the court refused to permit the sterilisation of an 11 year old child, even given medical and parental consent. Again, however, the court did not in fact make a general statement of rights for children, but rather felt that in this particular case, the child would eventually reach a condition in which she would be legally capable of consenting to marriage, and that therefore she would be entitled to recognition of her right under the European Convention on Human Rights[70] and the Universal Declaration of Human Rights,[71] to marry and found a family.

In terms of the kind of right described here, therefore, it can be seen that current attitudes would not facilitate its routine application to children unless a) the child is 'mature' and b) the child's decision accords either with that of the parents or that of the court. Yet, the position overtly adopted by courts seems to differ from this somewhat bleak analysis. Lord Brandon, for example, in the case of <u>R v D</u>[72] said:

> In the case of the very young child, it would not have the understanding or the intelligence to give its consent, so that the absence of consent would be a necessary inference from its age. In the case of an older child, however, it must, I think, be a question of fact for the jury whether the child concerned has sufficient understanding and intelligence to give its consent .....While the matter will always be for the jury alone to decide, I should not expect a jury to find at all frequently that a child under 14 had sufficient understanding and intelligence to give its consent.[73]

Or, as Lord Scarman put it in the Gillick[74] case:

> ..... I would hold as a matter of law that the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates if and when the child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed.[75]

As has been seen, therefore, courts are apparently reluctant to commit themselves to an overt recognition of children's rights *per se*. However, they are prepared, in certain circumstances, and provided that certain criteria are satisfied, to acknowledge the validity of a given child's viewpoint. In terms of the right as formulated here, however, the imposition of additional criteria might seem to be discriminatory, and therefore to defeat the right itself. More important would seem to be the, perhaps natural, conservatism of the court system. To intervene in family life is admittedly not something to be undertaken lightly, but neither is the denial of a basic right - that is the right to be given and be permitted to use information in relation to matters affecting the individual's health. Moreover, a reluctance to weigh the child's over the parent's view may simply reflect a failure to understand the significance of individuality. It has been said, for example, that:

> Courts tend to view the family as a unit and to assume that the parents' interests are the same as the child's. It is possible, however, to separate the interests of parents and child: a parental decision regarding a child's medical care is, in effect, "other-regarding" and not "self-regarding". Even if the decision purports to be in the child's best interests, it is still made by someone external to the child.[76]

At the moment, therefore, it is not overstating matters to say that the courts (if somewhat grudgingly) are prepared to give a certain amount of autonomy to certain individual children. The child's position at law is evidently rather complex. On the one hand the law seems prepared to concede that the mature child can make autonomous choices about a number of matters, including health care, while on the other, this concession apparently rests not on a clear attribution of rights to children but rather on the court's assessment of a number of other factors. Thus, rather than assuming the capacity to exercise a given right, as the law would theoretically do with adults, a number of other criteria have to be satisfied before a child will be given the benefit of the protection afforded by the right.

Most notably, the court has to be satisfied that the child is sufficiently 'mature' (however that is defined) and that the child's choice is in his or her 'best interests', as decided either by the parents or by the court. Rights, it would appear, can presently be restricted by such qualifications. Thus, there are evident difficulties for those who would wish to ascribe the right here defined to those under the age of 16. This right is dependent on autonomy - indeed, it may even be said that it is <u>justified</u> by autonomy. The discussion of the position of children in the law would not seem to indicate, however, that British courts are prepared to give serious consideration to the question of whether or not children, factually as opposed to legally, <u>are</u> autonomous. However, it is clear that there is a move away from a blanket assumption that children are not autonomous, towards acceptance that some of them may be. Nonetheless, such autonomy as is granted seems likely, at present, to be limited - most especially by the apparent truth that children will be given decision making powers only where their choice is thought to be rational. Now, it was also central to the right as described that it encompasses the right to behave in a manner which, medically at least, could be considered 'irrational'.[77]

If, therefore, so substantial a group as children are apparently excluded from the right, then one might wish to argue that it becomes less of a right, and more of a courtesy. If this situation is to be altered then the problems of attribution of the right to children must be tackled, and in particular, two questions require to be answered. First, are current problems insurmountable, and second, if some concessions do require to be made to paternalism, do they sabotage the right?

By accepting, in some cases, that children can consent, or withhold consent, in respect of medical treatment, the courts may be said to be accepting that, at least in certain circumstances, children may validly make choices about health care. In this respect, at least, they may be said to recognise a limited applicability of the right, and by so doing they are demanding that all aspects of the right are satisfied. Thus, the child may be protected at least by that aspect of the right which relates to information disclosure. In other words, at least part of the right is required before the child can make any kind of a choice. However, clearly information disclosure per se is insufficient to satisfy the right, since it is the authority to act on that information which permits the making of autonomous decisions. Merely to say that children have the right to information, therefore, would not be sufficient for those who would argue for children's rights in health care.

Thus, the more contentious aspect of the right becomes particularly important. If, however, the child's choice is only given credibility when it accords with what others regard as rational or appropriate, then the child is severely disadvantaged. The addition of qualifications about maturity and intelligence when coupled with this apparent requirement of rationality both restricts access to information and limits freedom of choice. It is, in fact, almost double jeopardy for the child. On the one hand, he or she needs to convince that he or she is intelligent and mature, and thereby merits information disclosure, whilst on the other hand if that information is used 'unsatisfactorily' or 'irrationally' by the child in reaching a conclusion on it, then they may be redefined as insufficiently mature to make a valid choice. The welfare model which dominates child law serves to restrict freedom of choice unless that choice satisfies the opinions of others. Thus, an affirmative decision by a child to opt for therapy would likely receive support in the way that a negative decision may not and yet, as Hoggett says:

> ..... the capacity to consent must logically include the capacity to dissent: if, then, parental control is diminished to the extent that the child herself has acquired capacity, the parents should have no power to insist ..... a duty to provide adequate medical aid does not necessarily import a power to force it upon a competent child who has rejected it.[78]

However, the value of the right to consent to medical treatment is not in itself modified or defeated by current decision-making parameters, nor by apparent current confusions as to the status to be accorded to children. Indeed, the courts themselves have been ambivalent about the standing of parental decision-making in respect of treament for their children. In the Arthur[79] case, the court was impressed with the fact that the parents opposed therapy, whilst in Re D (a minor) (wardship proceedings)[80] and Re B (a minor)[81] the courts were prepared to go against parental views. Moreover, in the case of Re B (a minor) (wardship proceedings) (sterilization)[82] the court made it clear that parents alone could not make decisions about the sterilisation of their children, and that the authority of the court was needed for such a major step, particularly where a human right was involved.

If it is, therefore, accepted that parents do not have absolute rights over their children (even, it would appear over a very young child), then it can also be accepted that courts have neither a supervisory monopoly on what is in the best interests of the child, nor do they require to deny the application of rights, at least to the child who is capable of expressing a view. To accept this, would be to alter the basis of decision-making in respect of children and to permit and authorise the child to make treatment decisions more often than is currently the case - particularly where the child's choice is to reject therapy. It is submitted that the real barrier to such a position is the confusion engendered by the apparent rigidity of the law's adoption of an age at which maturity and discretion can be attributed.

As has been noted, even the courts themselves are reluctant to assume any finality associated with mere age, but there seems, nonethless, to be a knock-on effect from age-barriers which makes courts suspicious of at least of some of the decisions which children may wish to make. Cases concerning children under this age require the courts to consider two issues which may well conflict: first, the child's claims to have the right to make decisions which he or she regards as appropriate, and second, the court's own responsibility to act in the best interests of the child. Clearly, there is as much scope for disagreement between courts and children as there is between parents and children.

However, de-emphasising the artificial age barrier could pave the way for more children to be accorded the authority to make autonomous choices which is so central to the right as described, and need not threaten either the family unit, or the protective role of the courts. It is conventional wisdom that children mature at different rates, and some would claim that they mature younger in contemporary society. For courts to begin by making the assumption of maturity (where the child can express a view), rather than the assumption of immaturity, would be to respect this, would not be an unusual judicial step and would adequately reflect the position of children in contemporary society. Lord Fraser, indeed, would seem to have acknowledged the need for the law to take account of this position, when he said '[s]ocial customs change, and the law ought to, and does in fact, have regard to such changes where they are of major importance.'[83]

Further support for the suggestion that the law does in fact acknowledge the autonomy of the child can be gleaned from the fact that the age of criminal responsibility is considerably lower than the apparent age of consent to medical treatment, and yet the attribution of criminal responsibility implies that the child is capable both of making choices to behave in a given way and of bearing the consequences (however harsh) of that behaviour. In other words, children already are credited with the capacity to make self-determining choices at a very early age, and indeed, a Scottish court has held a child of 5 to be capable of behaviour which amounts to contributory negligence.[84]

Further, it is not apparent that the age at which a child is presumed capable of making choices in the important area of health care need be set at the age at which <u>most</u> children would be capable of so doing (e.g. 16). To make a preliminary presumption of authority below that age would not defeat the role of the court in having the welfare of the child as its paramount consideration. Merely, it would require justification for <u>not</u> accepting the child's views, rather than as at present almost requiring justification <u>for</u> accepting them. In doing this, the courts or parents would be required to show a good or compelling reason why the child's view should not be authoritative, and this could be done in a consistent and logical manner and within a clear framework.

The advantages of this approach are many, not least that the protection of the right to consent to medical treatment would be afforded to a greater number of young people. Moreover, were the question to be approached from this perspective, more certainty may be introduced into the law, since it would be necessary to elaborate the reasons for invalidation of the child's position, thereby providing guidelines for future resolution of disputes.

It is admitted, however, that this approach also expressly countenances that here are some children whose views would be overridden, and this leads to the second question posed _supra_, namely, does the acceptance of limitations defeat the right itself? It is conceded that it may, in the case of children - or at least some children - be necessary to consider whether or not their choice is in fact based on both adequate disclosure of information and on an understanding of that information and the implications of the choice. It would, for example, be evident nonsense to suggest that a baby should have the _practical_ right to make choices about therapy. However, it may also be thought that:

> If a consent is real provided that the patient understands in broad terms what is proposed and agrees to it, then logically the

> capacity required of the patient to give that consent should not be great. A child who is capable of understanding the proposed treatment in such terms should be able to give her own consent.[85]

Moreover, making the fundamental assumption for rather than against capacity both extends the ambit of the right and removes the essential discrimination which is inherent in current attitudes. It further defeats some of the paternalism which is evident in judicial or parental decision-making, and permits children access to information about their health care and the freedom to make decisions which they regard as being in their best interests. To place some limitations on a given child's legal capacity to make such decisions does not, therefore, sabotage the right. Rather it may be said to enhance it, since the assumption of the value of free decision-making re-emphasises the importance which is attached to the right itself. It is submitted, however, that for the moment the debate is approached from an erroneous perspective, which both diminishes the value of the right and fails to reflect the differential capacities of children.

Limitations may, therefore, be placed on the exercise of the right without affecting its fundamental significance. Indeed, these limitations may well be invoked as a recognition of the value of autonomy. For example, courts may only choose to intervene where the decision made by the child would deny him or her the capacity to become autonomous. As Hoggett puts it:

> The distinction between knowing what is involved and having the capacity to make a wise decision is an important one. In the case of an adult, it is axiomatic that understanding, not wisdom, is all that is required for a man may go to the devil if he chooses. Perhaps in the case of a child, it is permissable to ask for more, on the ground that the first and paramount consideration throughout the law is the welfare of the child herself, so that the only treatment which anyone may permit is that which will promote her welfare.[86]

Adoption of the right in the case of children would, therefore, imply in the one case that parents could not authorise medical behaviour which causes the death of their child. But the converse could equally be said to be true - that is, that the only situation in which someone may interfere with the decision of a child is where the child's decision is a threat to his or her welfare, a threat, moreover which, since the overriding of the child's choice repesents the denial of a right, must be grave.

In conclusion, therefore, the fact that some limitations may have to be placed on a child's capacity to exercise the right to consent or not to medical treatment need not be seen as fatal to the right itself. Nor is it inimical to the claim that the right should be extended to children, and that this should be the cornerstone of decision-making in this area. It is not unusual for rights, even those which are said to be fundamental, to be nonetheless subject to some limitation,[87] but conflict is resolved from the perspective that the right is in operation and that it does have value. Thus, good reasons have to be shown for interference with its exercise. There is no reason why such an approach should not equally be applied to children's rights in health care.

## Consent and the Mentally Ill

The example of children is a significant one for the purposes of this discussion, because children are generally subject to disabilities very similar to those which affect other groups whose autonomy may be in doubt. If one can legitimately argue that the rationale underlying decision-making in respect of children should depend on the presumption of capacity, and that limitation of that capacity should demand stringent and consistent application of formal rules, then it is relatively simple to argue the same case for the mentally ill and the mentally handicapped.[88] The crucial characteristic shared by each group is the apparent simplicity of making certain blanket assumptions of lack of capacity from which deviations must be justified, whereas the thrust of this argument is that the most efficacious way of protecting these groups without going to the extreme of denying them basic rights is to assume capacity, and to demand proof of its lack.

Accepting the validity of the approach adopted regarding children, requires relatively brief consideration of the other groups. It has already been noted that the law is not obliged slavishly to follow medical diagnosis of mental ill health. Nor need it anticipate that such diagnosis, where accurate, implies any more than the illness itself - in other words, it need not be a predictor of legal capacity or moral autonomy. If this is accepted, then even the anti-psychiatrists, such as Szasz,[89] would be satisfied with the appropriate legal response. As Mason and McCall Smith note:

> The imposition of involuntary treatment will not ..... be appropriate in all cases. It is important to recognise that there will be circumstances in which, although the patient is mentally ill, the illness need not have rendered him totally incompetent to make decisions.[90]

Thus, for example, it need not be assumed that a person is always incompetent merely because of the fact of involuntary admission.

As Campbell[91] notes, however, there may be some for whom treatment in the absence of consent is the only potentially autonomy-enhancing strategy. To accept this view is to adopt a modified account of autonomy theory, admittedly, but it need not be fatal to the demand for patients' rights in health care, when its use is carefully monitored and closely defined to apply in only the most extreme situations. As Campbell says, there would seem to be situations where an over-dependence on autonomy theories may result in significant harm to some patients who are acutely disturbed and distressed.[92] With due respect, this may be a valid position in respect of some very extreme cases, but the implications of adopting it as a more general approach would be unacceptable. Doubtless Campbell would agree that caution must always be exercised in making such presumptions where the potential outcome amounts to an invasion of the integrity of the subject. The position adopted by those who would advocate a 'right to treatment' which incorporates treatment without consent or against the wishes of the individual may be justifiable, but, it is submitted, it must be of limited applicability. Moreover, it demands more clarification than a simple claim that, adopting such a view may enable someone to lead a normal life or will relieve suffering. The concept of normality is both relative and subjective, and must be carefully considered if the proponents of this view are not, in fact, to be forced into a position of merely enforcing <u>their</u> view of normality on others. Equally, whilst it may be true that, in some cases, the welfare of the patient may suffer if autonomy is taken as inevitably the major 'good',[93] it is necessary to consider seriously what <u>is</u> welfare. These decisions, it is suggested in this discussion, should be made, if they must be, against a backdrop of respect for autonomy.

As with children, the fact that there are some members of the group for whom consent (or indeed refusal) based on information disclosure is little more than a charade, need not affect the validity of the claim of others (perhaps the majority) that they have the right to make free choices about their therapy. Just as children, in terms of this right, may have to be permitted to make choices which to others seem 'irrational', even harmful, so too the mentally ill may wish to refuse therapy which might improve their condition.

Indeed there are some characteristics of mental illness which may add to the pressure to accept that the mentally ill should be permitted access to the right. Not least of these is the very uncertainty of psychiatry itself.[94] This uncertainty begins with diagnosis and ends with therapy. Indeed, it is this uncertainty which is one of the commonest justifications used by the law to ignore categorisation when convenient. Equally, and perhaps even more significantly, psychiatric therapy remains of uncertain value, at least where society values 'scientific' quantification of result. Finally, on this point, there can be little doubt that all psychiatric treament is designed to modify behaviour. For this reason, its use is subject to a number of questions which do not apply, for example, to the treatment of a broken leg.

The situation of the mentally ill in respect of medical treatment, and their capacity to consent or not, was, if anything, less certain that that of the 'sane' adult human being until relatively recently. Some might argue, in fact, that there is an inherent paradox in the fact that legislation now clarifies the position of the most seriously mentally ill, and in particular that it specifically permits the imposition of certain therapy only with their consent,[95] whereas the adult who does not suffer from mental illness is required to run the gamut of the forensic lottery if he or she wishes to attempt a vindication of rights. Just as with those children who are incapable of expressing their opinion, it is necessary for some acutely mentally ill people, who effectively also cannot express their opinion, that decisions are taken on their behalf, by competent and disinterested authorities, which have at least the chance of bringing about a position in which they may become autonomous. Whilst this may be relatively more dubious in regard to the mentally ill, given the uncertain benefits of the therapy, it may equally be regarded as right-enhancing rather than right-denying. It is for this reason that some theorists, whilst opposed to paternalism in se, may nonethless argue that some of the mentally ill have a right to therapy - indeed, this may be the most important human right which can be ascribed to them, since through this right may come the right to autonomy, to liberty and perhaps even to life itself.[96]

This much may be uncontentious, and it is certainly not the task of this discussion to describe definitive parameters of where lines should be drawn. Nonethless, the general proposition can be accepted without denying the value or the general applicability of the right to consent, or withhold consent, to medical treatment. Indeed, it should be noted that the legislation mentioned <u>supra</u> relates only to those who are detained as a result of serious mental illness,[97] the presumption being that, unless the facts of the individual case prove to be different, the rest of those who are diagnosed as suffering from some form of mental illness will, and can, be treated in a similar manner to the remainder of the community. That this may not be entirely satisfactory will be considered in the conclusion of this discussion, but that the position <u>could</u> be satisfactory can scarcely be in doubt.

Again, therefore, it seems clear that there is great merit, as with children, in assuming capacity, and requiring compelling evidence which would deny that assumption, since the capacity of those diagnosed as mentally ill, even accepting the diagnosis, will vary. To make a blanket assumption is to deny a valued human right without appropriate consideration, and, if for no reason other than that, cannot easily be countenanced, and is certainly difficult to justify. The model proposed in respect of children, therefore, can equally well be used in respect of the mentally ill in the community. Such an assumption would, it is submitted, also serve to alleviate some of the difficulties confronted by those who are responsible for interpreting the terminology of legislation, and would place the right to autonomous decision-making about therapy in the forefront of the debate.

Of course, the crucial difference between the incapacity of children and that of the mentally incapax is clearly that the one is only temporarily incapacitated by age, whilst the other's incapacity stems from the very reason for which it is sought to impose treatment. This certainly lends some credibility to the position of those who would value a right to treatment, and who might equally seek to differentiate the child from the mentally ill. It is not denied that there may be some significance in this distinction, but it is doubted that the distinction can be used routinely to undervalue other human rights - indeed, even those who would seek to justify a right to treatment would not go this far.[98] What is crucial, therefore, is that a right, such as the right to treatment, which amounts to a denial of free will, but includes the possiblity of restoring it, should be subject to careful scrutiny and sparingly relied upon.

Thus, whilst there is no doubt that a conflict may exist between the right described here and other positions which also seek to enhance autonomy, there does seem to be a mechanism whereby compromise can be reached. In those cases where treatment is contemplated without consent the decision taken should be made from the perspective that autonomy, in medicine as in other areas of life, has a priority, and it must be a decision which can be, and is, justified by reference to clearly defined legal regulation, developed for the protection of the individual.

If this position, however, is to be of benefit to the mentally ill, at least in the first instance legal systems must value autonomy rights in medicine for the 'normal' citizen, since there can be no point in appealing to the 'normal' position where it is in itself unsatisfactory. With particular reference to the mentally ill, and against this backdrop, it may be desirable to seek the 'evolution of a form of psychiatric practice which is both sensitive to human rights and which is, at the same time, subject to an element of lay and legal control.'[99]

One further group remains to be considered, however, before conclusions can legitimately be reached about the general applicability of the right to consent to medical treatment, or the right to withhold consent, based on adequate information disclosure. Perhaps more than any other group, the mentally handicapped present a problem for the law, and because of this, for those who would argue for legal recognition of autonomy-enhancing rights in medicine. The complexities of the position regarding the mentally handicapped, therefore, require some analysis in this context.

## Consent and the Mentally Handicapped

In many ways, it is true to say, that a separate body of law has not been created for the mentally handicapped. As Ward says:

> ..... an understanding of the law of children helps with the less well developed law of the mentally handicapped, and indeed there has been a tendency for aspects of the law of the mentally handicapped to be stated by referring to equivalent concepts in the law of children.[100]

It is also clear that, both in the common law and in statute, the mentally handicapped are sometimes dealt with as if they were indistinguishable from the mentally ill.[101] This confusion, or lack of distinction, can have unfortunate consequences, particularly in the latter case, since the crucial distinction remains that the mentally ill may be treated with some hope of success, whereas mental handicap would seem more likely to be a life-long condition for which no therapy is available.

Perhaps through a lack of understanding of the nature of mental handicap, the law - as with children and the mentally ill - may find it tempting to assume general disability, an assumption which denies legal standing to the whole group. Yet:

> When it comes to mental incapacity, we have at one extreme the normal adult of full capacity, and at the other extreme the person completely lacking legal capacity. In

> between these extremes is an area of partial legal capacity, which, broadly speaking, is an area in which people have capacity for some legal purposes and not for others. This area of partial incapacity is not sub-divided in the law, and it therefore covers the whole spectrum from mild mental incapability until one crosses the threshold of complete legal incapacity .....[102]

However, it is clear that, as with children and the mentally ill, the law tends not to make entirely blanket assumptions about capacity, considering each individual case very much on its merits. This _ad hoc_ type of decision-making may indeed be necessary given the range and variety of degrees and types of handicap. Indeed:

> ..... the law has never sought to draw clearcut boundaries across the chart, so as to create categories similar to the age-groups of children. There are no generalised "packages" of law which apply to any particular range of disability. The law does not generalise to any great extent. It will define whether a particular individual has legal capacity for one particular purpose, at one particular time, and in one particular set of circumstances. It will define whether one particular form of legal intervention is or is not appropriate.[103]

However, it will be argued here, as in the sections dealing with the other groups who have some legal disabilities, that even _ad hoc_ decision-making is, and should be, undertaken against a background of respect for human rights.

In December 1971, the General Assembly of the United Nations adopted a charter of _Rights for the_

Mentally Handicapped Person.[104] The first and fundamental right contained in this agreement is as follows: 'The mentally retarded person has the same basic rights as other citizens of the same country and same age.'[105] Naturally, the charter does acknowledge that there may also be need for a right to proper medical care and 'physical restoration',[106] but its general sense requires acceptance of the moral equivalence of the mentally handicapped. This assertion of rights is important on two counts. On the one hand, the law - as has been said - seems somewhat confused, perhaps even ambivalent, concerning the status to be accorded to the mentally handicapped, and on the other this group has been historically vulnerable to exploitation. In some situations, this exploitation has been condoned by the law.[107]

In terms of therapeutic medical intervention, there seems little doubt that the handicapped person would be treated in the same way as a child. In terms of detention or reception into guardianship, their position is similar to that of the mentally ill.[108] In other words, they are always vulnerable to the assumptions of others as to their best interests, or to legal presumptions which categorise their decision-making in such a way as to validate it only in a situation where it seems rational - 'rationality' being closely linked with the view of the parent or guardian on the one hand, and the law on the other.

Like the other groups referred to in this section, the handicapped are also vulnerable to non-therapeutic intervention. The position of the handicapped in respect of basic human rights can, despite the United Nations agreement, be described as ambivalent. The discussion, supra of the cases of R v. Arthur[109] and Re B (a minor)[110] shows clearly that the fact of handicap can be sufficient to encourage juries and courts to make assumptions about the value of those lives. If, it might be asked, the attribution of the basic right to life is not always made in respect of the handicapped, then on what grounds could it make sense to insist on the attribution of admittedly less fundamental rights? This question can, of course, be answered relatively simply by reference to the argument that the fact that something happens currently need not imply its permanence or its correctness, and the section dealing with the rights of children may be called on in support of the view that to adopt a different, rights dominated, view may well relieve these problems.

The handicapped (in this case including the physically handicapped) are, of course at risk from the moment of conception. The Abortion Act 1967, bearing in mind the tragedy of Thalidomide, was at pains to permit the termination of any seriously handicapped pregnancy. Genetic screening being as sophisticated as it now is makes the detection of handicap in the womb more possible, and genetic counselling may either facilitate the decision to avoid a pregnancy where handicap is likely, or may provide the adult with the opportunity to choose abortion where the foetus is known to be suffering from severe handicap.[111] It is worthy of note that the section, which permits termination where severe handicap is shown, is the only section in the Act which authorises termination solely on the basis of this fact. Other terminations can only be authorised where the risk to the mother of carrying the child to term is greater than the risk of termination, or where the health of other children in the family would also suffer.[112] However, the fact that a child may be born with severe handicap is sufficient to merit termination of the pregnancy. Some of the handicapped, therefore, will not even be permitted to be born.

After birth, their rights are equally suspect. Although the utilitarian, such as Glover,[113] might argue that babies, having no interest in life, therefore can have no right to it, this scarcely reflects common morality or general law.[114] Indeed it is interesting that this argument is only used in regard to those who are not 'normal'. Any legal system which condoned or even countenanced the routine killing (whether by act or omission) of healthy and 'normal' babies would be regarded as an international scandal. Not even the consequential utilitarian argument that to terminate the life of a damaged baby may maximise the general good by encouraging the parents to have a subsequent (healthy) one,[115] can be taken seriously, unless the first argument is accepted.

The comments made in respect of children and the mentally ill can equally be taken to apply to the handicapped, although it may be true to say that, at least in some situations, the needs of the handicapped for the law to take a clear position on human rights are, if anything, even more acute. Perhaps more than any other of these vulnerable groups, the handicapped are at risk, not merely of therapeutic decisions being made without reference to, or despite, their wishes, but also of the imposition of a non-therapeutic measure. Thus, they are used here as an example of the potential for non-therapeutic intrusion since they remain the group most strongly represented in this area. Analysis of their position can be conducted by reference to a number of jurisdictions and highlights a number of revealing attitudes which, it is submitted, serve to reinforce the need to maintain at all times an awareness of, and respect for, human rights.

It is important at this stage to remember the distinction drawn <u>supra</u> between therapeutic and non-therapeutic medical intervention,[116] and to bear in mind also that the distinction between the two, outside of the experimental situation, can be blurred - indeed, can be manipulated. Whilst 'therapeutic' is generally taken to imply something which is of benefit to the patient, and 'non-therapeutic' as something which may benefit knowledge and/or future patients, there is very real sense in which the former could be, and is, interpreted in a somewhat different way. The assumption behind the use of the term 'therapeutic' is that it represents treatment of a medical condition and offers hope of benefit. Thus, chemotherapy, however unpleasant, may offer a hope of cure and is therefore therapeutic.

However, therapy which is designed to avoid social difficulties may also be forced into the framework of 'therapeutic' treatment, unless courts are very careful, and it is here that the vulnerability of the mentally handicapped is at its most acute. The courts of a number of jurisdictions have, in recent years, been asked to consider precisely this issue in respect, most often, of a request to sterilise a mentally handicapped woman in order, not to cure a pre-existing physical condition, but on the social ground that she may be unable to cope with a pregnancy, cannot be trusted to take contraception, and would be unable to look after any child born, the alternative being the trauma of an abortion.[117]

One thing at least is clear, however. Unlike the apparent, albeit limited, power of parents to make therapeutic choices in respect of at least some of their children, courts are loath to permit the making of such a major decision as sterilisation without the proper legal formalities being undertaken. This attitude reflects the United Nations view, which in Article VII[118] makes the following comment:

> Some mentally retarded persons may be unable, due to the severity of their handicap to exercise for themselves all of their rights in a meaningful way. For others, modification of some or all of these rights is appropriate. <u>The procedure used for modification or denial of rights must contain proper legal safeguards against every form of abuse, must be based on an evaluation of the social capability of the mentally retarted person by qualified experts and must be subject to periodic reviews and to the right of appeal to higher authorities.'</u>(emphasis added)

Thus, legal systems which demand court approval of proposed sterilisation of the mentally handicapped provide at least some of the safeguards demanded by the United Nations. However, against a philosophy which is prepared to stretch the concept of 'therapeutic' treatment, and which places less than sufficient weight on the value of certain human rights, the mere fact of court authorisation - whilst complying with the letter of the commitment - may not, in fact, meet its philosophy. Whether or not the handicapped person is an adult or a child will, in some jurisdictions, make an apparent difference to the capacity of courts to intervene. In England, for example, the use of wardship proceedings is thought to be competent only up to the age of majority, but not beyond, although recently a court has been prepared to authorise sterilisation and pregnancy termination on a young mentally handicapped woman.[119] In Scotland, the authority to make major decisions ceases at the age of majority.[120] In Canada, those over the age of 18 will be dealt with under the power of <u>parens patriae</u>, which essentially depends on the same type of decision-making.[121] In the United States, appeal may be made on behalf of the handicapped person by reference to Constitutional rights which it is held apply equally to all citizens.[122]

The history of involuntary sterilisation of the handicapped is a long one.[123] In the early part of this century (and in some states until comparatively recently) some United States courts were prepared to authorise sterilisation, and to deny the unconstitutionality of laws permitting its enforcement.[124] These decisions must be seen against the background of the rapid rise of the eugenics movement in that country and its adoption by a large, and interestingly disparate, number of groups and individuals. For a time, therefore '[b]irth control became an issue primarily in as much as it related to forcing those who could or would not voluntarily control their reproductive capacities, not to breed.'[125]

Nor was compulsory sterilisation randomly used. There was a very definite bias towards sterilising those who, it was said, would either weaken the genetic stock of the country or who would, in any event, scarcely miss the capacity to breed or note the denial of a human right.[126] Thus, involuntary sterilisation:

> ..... by 1950 had accounted for the sterilisation of over 50,000 persons in America, 20,000 in California alone. By 1964

> the accumulative total had reached 63,678. Of these persons, 27,917 were sterilised on grounds of mental illness, 32,374 on grounds of mental deficiency and some 2,387 on other grounds.[127]

The attitude towards the handicapped, therefore, however genetically unsophisticated, was that there was a real probability that their offspring would be as much of a drain on the state as they themselves were seen as being, and that in any event, they probably did not have rights in this area and wouldn't notice their removal even assuming they had them.[128] In Buck v.Bell,[129] for example, a case which involved the compulsory sterilisation of a mentally defective young woman, the court had this to say:

> We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call on those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to avoid our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.'[130] (emphasis added)

Again in State v. Troutman,[131] the court doubted even the existence of rights in the mentally defective, saying: '[i]f there be any natural right for natively mental defectives to beget children, that right gives way to the police power of the State in protecting the common welfare .....'[132]

With the exposure of the eugenics movement as scientifically dubious, and the well-documented atrocities of the Nazi regime, the United States began, however, to move away from overt and involuntary intrusion into the procreative practices of the mentally unsound. Cases such as Carey v. Population Services International,[133] and Skinner v. Oklahoma,[134] asserted the existence of a human right to procreate whose restriction demanded considerable and compelling justification. This was not, however, an entirely wholehearted move, although in the case of Katie Relf et al. v. Caspar Weinberger et al. in 1974 the court sounded a note of caution:

> We should not drift into a policy which has unfathomed implications and which permanently deprives unwilling or immature citizens of their ability to procreate without adequate safeguards and a legislative determination of the appropriate standards in light of the general welfare and individual rights.[135]

A mere two years later, however, a North Carolina court concluded that mental retardation, was an identifiable category, and given that 'such persons are in fact different from the general population' they 'may rationally be accorded different treatment for their benefit and for the benefit of the public.'[136] It is clear from these more recent decisions that the grounds on which courts are prepared to authorise sterilisation of the mentally handicapped are not in fact always therapeutic athough they may partially be so. In effect, they were concerned with the 'general welfare' as much as with the individual. In some cases, they may also have been concerned for the specific welfare of, for example, a parent who may feel that a sexually active handicapped dependent who becomes pregnant, or runs the risk of so doing, places a great strain on them, and may mean that they have to bring up any subsequent child.

Indeed, courts in the United States have further blurred the distinction between therapeutic and non-therapeutic medical intervention by, in some cases, apparently assuming that the risk of pregnancy alone is sufficient to merit the sterilisation being considereed as therapeutic and not merely contraceptive. For example, no clear distinction between the two was made in the 1976 case of <u>In Matter of Sallmaier</u>,[137] where the court said:

> The decision to exercise <u>parens patriae</u> must relfect the welfare of society as a whole, but mainly it must balance the individual's right to be free from interference <u>against the individual's need to be treated</u>, if treatment would in fact be in his best interest.[138] (emphasis added)

Canadian courts too have considered these questions, most recently in the case of "<u>Eve</u>".[139] In this case, the court was unprepared to adopt a disingenuous approach to the nature of therapeutic and non-therapeutic treatment of the mentally handicapped. "Eve" is an adult who suffers from mental handicap, and who, it was thought, ran the risk of pregnancy. Her own capacity was such that she could not legally give her consent to the operation herself, and the court was asked to exercise its <u>parens patriae</u> jurisdiction to authorise the surgery (in this case, sterilisation by means of hysterectomy).

The court noted that the proposed surgery was 'admittedly non-therapeutic',[140] that is, it was not needed to deal with a medical condition, but merely to provide effective contraception. The purpose of the surgery was explained by the court as follows:

> One such [non-therapeutic] purpose is to deprive Eve of the capacity to become pregnant so as to save her from the possible trauma of giving birth and from the resultant obligations of becoming a parent, a task the evidence indicates she is not capable of fulfilling ..... it should be noted that there is no evidence that giving birth would be more difficult for Eve than for any other woman. A second purpose of the sterilization is to relieve Mrs. E. [Eve's elderly mother] of anxiety about the possiblity of Eve's becoming pregnant and of having to care for any child Eve might bear.[141]

In reaching its decision, the court undertook a thorough review of English, American and Canadian cases and provides an excellent analysis of the law and the points of principle which are central to the debate. LaForest, J., who delivered the judgement of the court, noted for example the extreme caution which courts must use in exercising their parens patriae powers, particularly where the exercise of that power would affect fundamental rights.[142] Noting that the scope of the power was historically unlimited, he was unprepared to concede that this entailed authority to make any decision. Rather:

> ...it by no means follows that the discretion to exercise it is unlimited. It must be exercised in accordance with its underlying principle ..... It is a discretion, too, that must at all times be exercised with great caution, a caution that must be redoubled as the seriousness of the matter increases.[143]

In particular, the court considered the earlier decision in Re K,[144] where the Court of Appeal in British Columbia ordered that a hysterectomy be performed on a seriously retarded child on the basis that the operation was therapeutic given the child's alleged phobic reaction to blood which, it was thought, might present serious emotional problems at the onset of menstruation. In taking this decision, the court was at pains to point out that their conclusion hinged on the individual circumstances of the case, Anderson, J.A. saying 'I say now, as forcefully as I can, this case cannot and must not be regarded as a precedent to be followed in cases involving sterilization of mentally disabled persons for contraceptive purposes.'[145]

Faced with a considerable weight of evidence in respect of the impact of sterilisation, the fact of its irreversibility and with their concern for basic human rights, the court in "Eve" concluded that the operation could not be authorised by them. As the court said:

> .....the decision involves values in an area where our social history clouds our vision and encourages many to perceive the mentally handicapped as somewhat less than human ..... Moreover, the imlications of sterilization are always serious.[146]

The court had the advantage of consulting a report of the Law Commission of Canada,[147] which reviewed the available evidence in respect of sterilisation, and felt able to reach certain conclusions on its use in a non-therapeutic context in the case of the mentally handicapped. They stated for example that:

> .....like anyone else, the mentally handicapped have individually varying reactions to sterilization. Sex and parenthood hold the same significance for them as for other people and their misconceptions and misunderstandings are also similar ..... The psychological impact of sterilization is likely to be particularly damaging in cases where it is a result of coercion and when the mentally handicapped have had no children.[148]

The court in "Eve" therefore, concluded that:

> The grave intrusion on a person's rights and the certain physical damage that ensues from non-therapeutic sterilization without consent, when compared to the highly questionable advantages that can result from it, have persuaded me that it can never safely be determined that such a procedure is for the benefit of that person. Accordingly,

> the procedure should never be authorised for non-therapeutic purposes under the <u>parens patriae</u> jurisdiciton.'[149]

For the purposes of English law, Scottish courts not having directly considered the problem, it is worthy of note that this thoroughly reasoned and rights dominated judgement refered with considerable favour to the judgement of Mrs Justice Heilbron in the case of <u>Re D (a minor) (wardship proceedings)</u>.[150] The facts of this case relate to the proposed sterilization of an 11 year old girl who suffered from a syndrome which, amongst other disabilities, resulted in mental handicap. Both the girl's mother and her doctors had agreed that sterilisation was approriate in order to avoid the risk of pregnancy and the problems of the girl being unable to care for any child which she might have. The decision to sterilise was challenged and wardship proceedings were raised in order to place the child within the protection of the courts.

The wardship jurisdiction is designed to protect those who are thought to be incapable of protecting themselves, and its scope is wide. As Latey, J. said in <u>Re X (a minor)</u>:[151]

> '..... the powers of the court in this particular jurisdiction have been described as being of the widest nature. That the courts are available to protect children from injury whenever they properly can is no modern development.[152]

Protection of the interests of a child can be given a relatively wide interpretation, as in the case of Re S v. McC; W. v. W.,[153] where the court authorised, in exercise of its protective jurisdiction over an infant, the taking of blood tests from a husband, his wife and child in an attempt to ascertain paternity.

As the court noted in "Eve", however, the fact that the jurisdiction is wide does not mean that the court can authorise activities which are outside the underlying principles, and to this extent they were in agreement with Mrs. Justice Heilbron's decision in Re D (a minor) (wardship proceedings).[154] Both of these judgements relied heavily on a rights dominated approach in order to deny the validity of non-consensual, non-therapeutic sterilisation of a mentally handicapped person. Mrs. Justice Heilbron presents the matter thus:

> It is apparent ..... that the jurisdiction to do what is considered necessary for the protection of an infant is to be exercised carefully and within limits ..... The type of operation proposed is one which involves the deprivation of a basic human right, namely the right of a woman to reproduce, and therefore it would, if performed on a woman for non-therapeutic reasons and without her consent, be a violation of such a right.[155]

However, unlike the Canadian decision, this decision left available loopholes which have now been taken advantage of. The court in the case of (Re B (a minor) (sterilization),[156] whilst noting the decision in Re D with approval, nonethless felt able to distinguish it from the case under their consideration. The apparent reason for this distinction was the court's claim that the operation was therapeutic in nature, but it is questionable whether such a claim can indeed be justified, and in any event it reflects the position which the court in "Eve" were at pains to criticise - namely, the blurring of distinctions in the interests of social or other considerations.

This English case concerned the proposed sterilisation of a 17 year old mentally handicapped girl, who, it was said, would at best achieve the intellectual and motor skills of a 5 or 6 year old. It was thought that she was beginning to show signs of sexual awareness and interest, and her mother felt that the best method of avoiding unwanted pregnancy would be to arrange for her to be sterilised. The evidence was that she would be unable to take the contraceptive pill for medical reasons, but also because she might not remember to do so, and the court presented the alternative to this as being the permanent removal of her capacity to procreate. They concluded that:

> The court had jurisdiction to authorize a sterilization operation on a ward of court in wardship proceedings but it was jurisdiction which should be exercised ony as a last resort when all other forms of contraception had been considered. Moreover, there was no question of a natural parent or local authority having parental rights giving consent to a sterilization operation without first obtaining the leave of the court in wardship proceedings.'[157]

The latter aspect of their judgement seems to reflect the commitment to legal control which was advocated by the United Nations, although it may again reflect the letter rather than the spirit of the U.N. commitment,[158] unless Article 1 of that same declaration is intimately linked to the exercise of judicial authority. Moreover, the former leaves room for some argument. Some dubiety, for example, has already been expressed as to whether or not the options as presented by the court are in fact the only ones available.[159] Further, the judgement seems not to be disposed to consider the situation in all its gravity from the perspective of human rights, dismissing the rights argument on the basis that 'As far as she was concerned the right to reproduce would mean nothing to her.'[160] The dangers of making access to rights dependent on awareness of them, or an interest in them, are clear and do not require restatement here.

The court was also able to take advantage in reaching its decision of one major loophole in the Re D judgement. Despite the apparent vindication of the rights of the young child in that case, the decision was in fact considerably less rights dominated than at first appears. In Re D, it was confidently anticipated that the girl would have the legal capacity to marry, and she was therefore protected by the right to marry and found a family as propounded in the European Declaration of Human Rights.[161] The fact that she would be able to consent to marry was a cornerstone of the court's decision not to authorise the sterilisation.

In Re B,[162] however, the young woman will clearly never be in that position and, unless the right to reproduce were considered absolute, or a real value were placed on the need for consent from the individual based on information disclosure, the court felt free to make the decision it did in authorising the operation. As a leading article in 'The Observer' noted in the aftermath of this case:

> English law on this is in a mess. Every year, some dozens of handicapped girls are discreetly sterilised by specialists at the request of their parents, but nobody knows whether it is legal or not ..... Britain urgently needs better law and regulation for such cases.[163]

One could scarcely agree more.

## Conclusions

This lengthy discussion of the position of the mentally handicapped has been undertaken to reinforce the vulnerability of the special groups, not only in terms of their involvement in therapeutic medical acts, but also in regard to those which either are non-therapeutic, or which are therpautic only by legal sleight of hand. As LaForest, J. says: '..... sterilization may, on occasion, be necessary as an adjunct to treatment of a serious malady, but I would underline that this, of course, does not allow for subterfuge or for treatment of some marginal medical problem.'[164] (emphasis added) What, it is suggested, has emerged from this discussion is that there are two main schools of thought currently adopted in decision-making in these cases. Leaving aside the now largely discredited manipulation of children, the mentally ill and the mentally handicapped for social or eugenic reasons, the picture can be presented thus.

Most of the decisions reviewed have started from the presumption of incapacity - the persons so defined are then left with the task of establishing that they are capable of making decisions for themselves, a task seriously hampered by the initial presumption. Moreover, where capacity is in doubt and disputes arise, the courts have generally been tempted to adopt one of two approaches, sometimes seeking to justify the outcome in terms of both. These approaches are referred to as the 'best interests approach' and the 'substituted judgement approach'.

In the former, particularly prevalent in cases relating to mentally sound children, the presumption is that parents or courts can decide - indeed have a responsibility to decide - what is in the best interests of a given child. That their conclusion in some cases may result in the child's death seems not to have been a matter of grave concern. Nor does it seem to be regarded as significant that the decision to impose or withhold therapy may conflict with the views or the rights of the child him or herself. In these cases, the preference for therapy over non-therapy dominates the attitude of society and the courts, rendering the opinion of the reluctant child apparently less weighty than would be that of a child who sought treatment in the face of parental objection.

This attitude also pervades much of the law in relation to the mentally ill, with the additional complication of the fact that it is argued a) that it may be their illness itself which makes them wish to reject therapy and b) that there may be, albeit in limited circumstances, a 'right to treatment', which by its very nature denies the value of the patient's choice against therapy. It is, therefore, 'in their best interests' to be treated, and not to have their own view or position validated.

Societal concern for the best interests of those whose legal and moral standing is in doubt, is equally appropriate in the case of the mentally handicapped, although in their case it can be said that the pendulum has swung even further away from respect for the rights of the individual, at least in the example of compulsory intervention in reproductive freedom. For all of these groups, competition with those in authority (either parents or courts) is a truly unequal struggle.

The second approach adopted would justify treatment without consent on the grounds that, had the person been in a position to give or withhold consent, they would have opted for therapy. This is often taken as self-evident, since surely people prefer the hope of cure or alleviation of symptoms to the prolongation of ill-health? Yet, if the right described in this discussion is to have any real meaning it must inevitably include the right to prefer no treatment - in other words, to prefer illness to the possibility of cure. This 'substituted judgement' approach has gained a certain credibility in decision-making in difficult areas such as these, because, it is claimed, it seems to give more credence to the individual's standing as a human being than does the overtly paternalistic 'best interests' test. The logical flaw, however, is that the fact that the decision is <u>not</u> made by the indivudal denies the very basis of the justification for using this test

To return to the <u>"Eve"</u> case briefly, the judge, in response to advocation for the substituted judgement test, made the following statement:

> I do not doubt that a person has a right to decide to be sterilized. That is his or her free choice. But choice presupposes that a person has the mental competence to make it. It may be a matter of debate whether a court should have the power to make the decision if that person lacks the mental capacity to do so. <u>But it is obviously fiction to suggest that a decision so made is that of the mental incompetent. What the incompetent would do if he or she could make the choice is simply a matter of speculation.</u>'[165] (emphasis added)

Although sterilisation may seem to be a particularly intrusive action, these views can equally be translated into the more routine medical intervention. There may be additional significance attached to the final denial of the capacity to procreate, but there remains significance in _all_ medical intervention undertaken without the consent of the individual. That significance is vested in the value of the right to make independent decisions, free from duress, based on information and in the light of the personal implications of the outcome. _All_ therapy undertaken without consent is intrusive of the individual's integrity and invasive of the right to give or withhold consent.

What, then, can be concluded in respect of the general right from an examination of the special groups? It was suggested at the beginning of this chapter that, if these groups were to be routinely excluded from the ambit of the right, then its significance and value would be considerably diminished. What this discussion has, however, shown is that blanket assumptions need not be, and in fact are not, made by the law as to the capacity of children, the mentally ill and the mentally handicapped. However limited the ascription of rights, it nonetheless is there. Yet, there are restrictions imposed on access to information and on freedom to choose or reject therapy which may still pose problems. In particular, the nature of the tests adopted in the event of conflict present a serious threat to the number and range of persons who could claim the protection of the right. The question remains, therefore, whether or not this threat is inevitable and insurmountable.

There is no doubt that there are some members of the community who are incapable, whether by reason of age or mental incapacity, from taking decisions. The right to consent or not to medical treatment is for them not a reality. On the other hand, as was noted <u>supra</u>, the fact that they do not appreciate its value or cannot freely choose to exercise it is not in any way a negation of the right itself. The fact that the comatose have no known interest in life, and certainly cannot express a preference for it, does not entitle those in authority to authorise the removal of the right to life, nor does it diminish the overwhelming value placed on that right - indeed, it is precisely this value which precludes proxy decision-making of that sort in these circumstances. This is also true of the right to consent to or refuse medical treatment.

Accepting, therefore, that the right remains important, the fact that it may be denied to some need not be fatal to its place on the list of rights to which humanity can aspire. Indeed, the examples of children, the mentally ill and the mentally handicapped serve rather to reinforce the need to take the right seriously. Neither of the currently favoured approaches to decision-making is satisfactory, substantially because both begin from the wrong premise. Certainly, restrictions may have to be imposed, but the presumption should be that the right has priority. If this were the approach adopted then fewer individuals would be precluded from its protection. It is admitted that such an approach may in some rare cases preclude therapy altogether, but it is argued that the morality of the proposed therapy in these cases would in any event be somewhat dubious - for example, the sterilisation for non-therapeutic purposes of those whose consent cannot be obtained. The responsibility, were the right taken seriously, would pass from those who are vulnerable to those in authority, to demonstrate a manifest and acceptable justification for proceeding without consent, and would reinforce the rights of all individuals to have access to the full panoply of civil and moral rights.

These conclusions have importance for the sane, adult also. If the fact that courts do not presently respect the rights of special groups to involvement in a therapeutic alliance were to be considered fatal to the right itself, then the fact that the right is also badly defined, and sometimes ignored, in the case of the sane adult would necessarily imply the same conclusion. This is a position which even the most rampantly paternalistic would surely find unacceptable. The solution, therefore, lies not in the continual erosion, redefinition or categorisation of those to whom the right is applicable, but in a radical re-thinking of the right itself - its scope, its nature, its value, and most crucially of all, its legal status and the corresponding mechanisms for its vindication.

## NOTES

1. see chapter 2, supra.
2. that is, legally incapable.
3. Walker, D.M., Principles of Scottish Private Law, (3rd. Ed.), Oxford, Clarendon Press, 1982, Vol. 1.
4. op.cit., at pp. 211-212.
5. c.f. the comments of Lord Fraser in Gillick v. West Norfolk and Wisbech Area Health Authority & Anor. [1985] 3 All E.R. 402, [1985] 3 All E.R. 830.
6. In Scotland the age of criminal responsibility is set at 8. In England the common law age was 10, but this was theoretically raised to 14; for discussion, see McLean, S.A.M. and Grant, J.P., 'Police Contact with Children under Eight: The Under-Age "Offender"', (1981) J.S.W.L. 140..
7. for discussion, see e.g. Walker, op.cit., particularly at 3:1 and 3:2.
8. for further discussion, see pp 500-537 infra.
9. most notably through the Mental Health (Amendment) Act 1983 and the Mental Health (Amendment) (Scotland) Act 1984. The Scottish legislation applies 'consent to treatment' requirements only

to those who are detained patients (part X)

10. for a full discussion of criminal law and the mentally ill see Gordon, G.H., The Criminal Law of Scotland, (2nd Ed.), Edinburgh, W. Green & Son Ltd., 1978; Williams, G., Textbook of Criminal Law, (2nd Ed.), London, Stevens & Sons, 1983; Halleck, S.L., Psychiatry and the Dilemmas of Crime, Berkeley, University of California Press, 1971; Chiswisk, D., 'Use and Abuse of Psychiatric Testimony' (1985) 290 Brit. M. J. 975.

11. see Gordon, op.cit.; Williams, op.cit.

12. c.f. Maher, G., 'Same but Abnormal' in McLean, S.A.M., (ed) Legal Issues in Medicine, Aldershot, Gower, 1981.

13. c.f. Silverman, G., 'Psychiatry After Sutcliffe' (1981) 125 Sol. Jo. 518; but see R v. Mathieson [1958] 2 All E.R. 87; Taylor v. R. (1978) 22 A.L.R. 599; Mason, J.K. and McCall Smith, R.A., Law and Medical Ethics, (2nd Ed.), London, Butterworths, 1987, chapters 18 and 29, and at p. 298: '...the weight given to psychiatric evidence by a court may depend in large measure on the circumstances surrounding the case.'

14. supra cit.

15. at p. 419

16. for discussion, see e.g. Harris, P., An Introduction to Law, (2nd Ed.), London, Weidenfeld and Nicolson, 1984.

17. for discussion, see Walker, *op.cit*; Hoggett, B., and Pearl, D.S., The Family, *Law and Society*, London, Butterworths, 1983.(2nd Ed. 1987)

18. c.f. Walker *op.cit.*; Hoggett, *op.cit.*

19. *op.cit.* at p. 278.

20. *op.cit.* at pp. 278-279.

21. for a brief discussion, see pp.477-80 *infra.*

22. per Lord Denning in *Hewer* v. *Bryant* [1969] 3 All E.R. 578, at p. 582.

23. *Hannah* v. *Hannah* 1971 S.L.T. (Notes) 42: 'It is not nature but the welfare of the child which is the material matter.'; see also Children and Young Persons Act 1933; Children and Young Persons (Scotland) Act 1937; Criminal Procedure (Scotland) Act 1975; Social Work (Scotland) Act 1968; *R* v. *Senior* [1899] 1 Q.B. 283; *R* v. *Spencer and Spencer* (unreported 1958); *Oakey* v. *Jackson* [1914] 1 K.B....; *R* v. *Hayes* [1969] 1 Q.B. 364; *Andrews* v. *D.P.P.* [1937] A.C. 576; *R* v. *Lowe* [1973] Q.B. 702.

24. e.g. *Gover* v. *Gover* 1969 S.L.T. (Notes) 78.

25. for discussion, see Sher, E.J., 'Choosing for Children: Adjudicating Medical Care Dsiputes Between Parents and the State' *58 N.Y.U.L. Rev.* 157 (1983).

26. *supra cit.*

27. at p. 420

28. *supra cit.*

29. at p. 78.

30. see chapters 5 and 6, *supra*

31. for discussion, see Sher, *loc.cit.*

32. *id.*

33. Sher, *loc.cit.*; see also *In Re Karwath* 199 N.W. 2d 147 (1972); *In Re May* 95 Misc. 2d 1026 (1978); *Custody of a Minor* 378 Mass. 732 (1979); *In re Hofbauer* 47 N.Y. 22d 648 (1979).

34. for discussion, see Dickens, B., 'The Use of Children in Medical Experimentation' *43 Med-Leg J.* 166 (1975).

35. *H.L.* v. *Matheson, Governor of Utah et al*. 450 U.S. 398 (1981); for further discussion see Sher, *loc.cit.*; see also *City of Akron* v. *Akron Centre for Reproductive Health Inc. et al.* 103 S. Ct. 2481 (1983)

36. although privacy is not *in se* a right guaranteed by the Constitution, it has become customary to refer to it in a number of cases, e.g. *Roe* v. *Wade* 410 U.S. 113 (1973).

37. for further discussion, see pp.486-9 *infra.*

38. *supra cit.*

39. [1984] 1 All E.R. 365.

40. at pp. 373-375.

41. Walker, *op.cit.*, at p. 202.

42. *id.*

43. Walker, *op.cit.*, at p. 203

44. for discussion of the 'best interests' approach,

see Goldstein, J., Freud, A. and Solnit, A.J., Beyond the Best Interests of the Child, London, Collier Macmillan, 1973; Goldstein, G., Freud, A and Solnit, A.J., Before the Best Interests of the Child, London, Burnett Books, 1980.

45. Consultative Memorandum No. 65, Legal Capacity and Responsibility of Minors and Pupils

46. at p. 44.

47. supra cit.

48. at pp. 47-48

49. at p. 51.

50. Gillick, supra cit. (H.L.)

51. at pp. 407-408

52. Matheson, supra cit.

53. Sher, loc.cit., at p. 164

54. id.

55. at p. 410

56. at pp. 410-411

57. supra cit.

58. Agar-Ellis v. Lascelles (1883) 24 Ch.D 317.

59. see Freeman, M.D.A., 'Freedom and the Welfare State: Child-Rearing, Parental Autonomy and State Intervention' [1983] J.S.W.L. 70.

60. c.f. Skegg, P.D.G., 'Capacity to Consent to Medical procedures on Minors' 36 M.L.R. 370 (1973); Cusine, D.J., 'To Sterilise or not to Sterilise' 18 Med.Sci. Law (1978) 120; McLellan, M.F., 'Jehovah's Witnesses and Child Protection

Legislation: The Right to Refuse Medical Consent' 1 Leg-Med Q 37 (1977); Dickens, B.M., 'The Modern Function and Limits of Parental Rights' (1981) 97 L.Q.R. 462.

61. see pp.486-9 infra.

62. for discussion, see Liu, A.N.C., 'Wrongful Life: Some of the Problems' (1987) J. Med. Ethics 69; Symmons, C.R., 'Policy Factors in Actions for Wrongful Birth' (1987) M.L.R. 269.

63. McKay v. Essex Area Health Authority [1982] Q.B. 1166, [1982] 2 All E.R. 771; Eyre v. Measday [1986] 1 All E.R. 488; Udale v. Bloomsbury Area Health Authority [1983] 2 All E.R. 522; Emeh v. Kensington & Chelsea & Westminster A.H.A. [1984] 3 All E.R. 1044.

64. see note 63, supra; but see also Gleitman v. Cosgrove 296 NYS 2d 689 (1967).

65. 'The Times' 6 November 1981.

66. id.; see also discussion of the professional standard in R v. Bateman (1925) Cr. App. Rep. 8; see also McLean, S.A.M. and Maher, G., Medicine, Morals and the Law, Aldershot, Gower, 1983 (reprinted 1985), chapter 4.

67. [1981] 1 W.L.R. 1421

68. [1976] 1 All E.R. 326, per Mrs J. Heilbron, at p. 332: 'The type of operation proposed is one which involves the deprivation of a basic human right, namely the right of a woman to reproduce, and

therefore it would, if performed on a woman for non-therapeutic reasons and without her consent, be a violation of such a right.'

69. for discussion of the right to reproduce, see McLean, S.A.M. 'The Right to Reproduce' in Campbell, *et al.* (eds), *Human Rights: From Rhetoric to Reality*, Oxford, Basil Blackwell, 1986.

70. Article 12.

71. Article 16(3).

72. [1984] 2 All E.R. 449.

73. at p. 457.

74. *supra cit.*

75. at p. 423

76. Sher, *loc.cit.*, at p. 164

77. see chapter 2, *supra.*

78. Hoggett, B., 'Parents, Children and Medical Treatment: The Legal Issues', in Byrne, P. (ed) *Rights and Wrongs in Medicine*, London, King's Fund (O.U.P.) 1986, at p. 158.

79. *supra cit.*

80. *supra cit.*

81. *supra cit.*

82. 'The Times' 17 March 1987; see also *T.* v. *T. & Anor.* 'The Times' 11 July 1987.

83. at p. 411

84. *Shillinglaw* v. *Turner* 1925 S.C. 807; for further discussion, see Walker, *The Law of Delict in Scotland*, (2nd Ed., revised), Edinburgh, W. Green

& Son Ltd., 1981, pp. 86-88, and pp. 368-370; Rogers, W.V.H., Winfield and Jolowicz on Tort, (12th Ed.), London, Sweet & Maxwell, 1984, pp. 155-156.

85. Hoggett, loc.cit.

86. id.

87. for example, the schema of the the European Convention on Human Rights is to state the right and immediately follow with the exceptions.

88. for further discussion, see pp.....infra.

89. c.f. Szasz, T., Law Liberty and Psychiatry, London, Routledge & Kegan Paul, 1974

90. op.cit., at p. 289; see also Freeman v. Home Office [1984] 1 All E.R. 1036; Barbara v. Home Office (1984) 134 N.L.J. 888; see also Somerville, M., 'Refusal of Medical Treatment in "Captive" Circumstances' 63 Canadian Bar Review 59 (1985).

91. Campbell, T.D., (1986) 'The Rights of the Mentally Ill' in Campbell, et al., supra cit; Campbell, T.D., 'The Rights Approach to Mental Illness' in Griffiths, A.P. (ed), Philosophy and Practice, Cambridge, C.U.P., 1985.

92. loc.cit., 1986.

93. for further discussion, see Gostin, L.O., 'Compulsory Treatment in Psychiatry: some reflections on self-determination, patient competency and professional expertise' 7 Poly Law

Review, 86 (1981).

94. See, e.g., Gostin, loc.cit.; Szasz, op.cit.

95. Mental Health (Amendment) Act 1983; Mental Health (Amendment) (Scotland) Act 1984.

96. c.f. Campbell, loc.cit., 1986.

97. at least in Scotland (part X of the 1984 Act).

98. c.f. Campbell, loc.cit., 1986.

99. for further discussion, see Olson, W.J. and Kanter, A., 'Patients' Rights' (1980) Annual Survey of American Law, 321.

100. Ward, A.D., Scots Law and the Mentally Handicapped, Edinburgh, Scottish Society for the Mentally Handicapped, 1984 at p. 2.

101. both the Scottish and the English legislation apply equally to both groups despite distinctions in the nature of their conditions - distinctions which may in fact be of considerable importance; for discussion, see Ward, op.cit., at p. 108 et seq.

102. Ward, op.cit., at p. 6.

103. Ward, op.cit., at p. 76.

104. for the full text, see Ward, op.cit.

105. Article I

106. Article II

107. e.g. Buck v. Bell (1927) 274 U.S. 200, per Holmes, J., at p. 207: 'We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could

not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence; for further discussion, see McLean, 'The Right to Reproduce', *loc.cit.*

108. see Ward, *op.cit.*, chapters V and VI

109. *supra cit.*

110. *supra cit.*

111. In Britain, in terms of the Abortion Act 1967 s 1(2); in the U.S.A. this would form part of the 'privacy' right described in *Roe* v. *Wade*, *supra cit.*

112. Abortion Act 1967 s. 1(1)

113. Glover, J., *Causing Death and Saving Lives*, Harmondsworth, Penguin, 1977.

114. c.f. Glover, *op.cit.*, chapter 12.

115. *id.*

116. see pp351-364, *supra.*

117. c.f. *Re K* (1985) 19 D.L.R. (4th) 255; *In the Matter of Sallmaier* (1976) 378 N.Y.S. 2d 989; *In Re Grady* (1981) 426 A 2d 467; but see, *Re D (A Minor)*, *supra cit.*; *Application of A.D.* (1977) 394 N.Y.S. 139; *"Eve"* v. *Mrs. "E"* 115 D.L.R. (3d) 283 (1986) - references to this case will be taken from a transcript.

118. Rights for the Mentally Handicapped Person (1971).

119. *Re B (Wardship Proceedings) (Sterilization)*, *supra*

cit.; but see, T v. T & Anor, supra cit.: 'His Lordship was convinved that it was in the best interests of the girl that the proposed procedures should be performed...[He] was content to rely on the principle that in exceptional circumstances where there was no provision in law for consent and no one who could give consent and where the patient was suffering from such mental abnormality as to be unable ever to give consent then a medical adviser was justified in taking such steps as good medical practice demanded.'

120. c.f. Walker, Principles of Scottish Private Law, op.cit., at p. 208.

121. for a description of wardship powers see Re X (A Minor) [1975] 1 All E.R. 697, per Latey, J., at p. 699: '...the powers of the court in this particular jurisdiction have always been described as being of the widest nature. That the courts are available to protect children from injury whenever they properly can is no modern development.'; Re S v. McC: W v. W [1972] A.C. 24; Heilbron, J. in Re D (a minor), supra cit., at p. 332: 'It is apparent...that the jurisdiction to do what is considered necessary for the protection of an infant is to be exercised carefully and within limits.'; Re P (a minor) [1982] C.L.Y. 2077.

122. c.f. Skinner v. Oklahoma 316 U.S. 535; Planned

<u>Parenthood of Central Missouri</u> v. <u>Danforth</u> 428 U.S. 52 (1976)

123. for discussion, see Meyers, D., <u>The Human Body and the Law</u>, Edinburgh, E.U.P. 1971, chapter 2.

124. c.f. <u>Buck</u> v. <u>Bell</u>, <u>supra cit.</u>; <u>North Carolina Association for Retarded Children et al.</u> v. <u>State of North Carolina et al.</u> 420 F. Supp. 451 (1976); <u>State</u> v. <u>Troutman</u> 50 Idaho 763 (1931).

125. McLean, <u>loc.cit.</u> at p. 105.

126. <u>State</u> v. <u>Troutman</u>, <u>supra cit.</u>; more recently in the United Kingdom, see <u>In Re B (sterilization)</u>, <u>supra cit.</u>, per Dillon, L.J., 'As far as she was concerned the right to reproduce would mean nothing to her.'

127. Meyers, <u>op.cit.</u>, at p. 29.

128. <u>Re B (sterilization)</u>, <u>supra cit.</u>

129. <u>supra cit.</u>

130. at p. 207

131. <u>supra cit.</u>

132. at p. 767.

133. 431 U.S. 678.

134. <u>supra cit.</u>

135. 372 F Supp. 1196 (1974).

136. <u>North Carolina Association for Retarded Children</u>, <u>supra cit.</u>

137. <u>supra cit.</u>

138. at p. 991.

139. <u>supra cit.</u>

140. at p. 13

141. at pp. 13-14

142. at p.59

143. at p. 53

144. *supra cit.*

145. at p. 275.

146. at pp. 53-54.

147. Law Commission of Canada, *Sterilization*, Working Paper 24 (1979).

148. at p. 50

149. at p. 59

150. *supra cit.*

151. *supra cit.*

152. at p. 699

153. *supra cit.*

154. *supra cit.*

155. *Re D*, *supra cit.*, at p. 332.

156. *supra cit.*; see also *T* v. *T*., *supra cit.*

157. *Re B (a minor ) (sterilization)*, *supra cit.*

158. Rights for the Mentally Handicapped Person (1971) Article VII

159. c.f. Amiel, B., 'The Rules of a Sterile Society' 'The Times' 30 July 1987: '...it was difficult not to conclude that this court was using the phrase "last resort" in a rather hypocritical fashion, enabling them to agree to sterilization without really facing what they were doing.'

160. per Dillon, L.J., *loc. cit.*

161. Article 12; for discussion of the possible implications of this, see McLean, S.A.M. and Campbell, T.D., 'Sterilisation', in McLean, S.A.M. (ed), Legal Issues in Medicine, Aldershot, Gower, 1981.

162. *supra cit.*

163. 'The Observer' 22 March 1987.

164. at p. 63

165. at p. 64.

# CONCLUSIONS - A WAY FORWARD?

## Chapter 9

This discussion has centred on the claim that a right to provide or withhold consent to medical treatment can be established. Such a claim is based on the respect which is traditionally accorded to the right of human beings to self-determination - a right which is routinely appealed to in many and varied situations as one of the fundamental constituents of respect for human life.

The argument here has been that this same right to self-determination exists in health care - indeed, that in matters such as health, which so fundamentally affect the capacity of the human being to participate knowledgeably in social affairs, self-determination has, if anything, an enhanced moral status. It has further been argued that even the benign and genuine motivation of orthodox medicine and the capabilities of its panoply of technological skills, cannot override the patients' rights to participate in therapy or experiments, or to withhold consent, only on a voluntary and knowing basis. The terminology of 'informed' consent has largely been eschewed since the theoretical perspective adopted here does not depend for its validity on patient understanding (which the term 'informed' is taken by some to imply and which may provide a justification for non-disclosure of difficult or highly technical information). In any event, direct translation of the American concept of 'informed consent' into British law would merely serve to bring with it the problems currently facing the American patient[1].

The right described, therefore, is taken to be a fundamental one and access to it is seen as vital to the human being's exercise of control over his or her own life and health (physical and mental). Moreover, the logical corollary of any such right is that information relevant to the risks and benefits of the proposed therapy and its alternatives must be disclosed in order that the patient can make a choice as to whether or not to participate. As in Re Quinlan[2] the right is taken to incorporate the right of a competent person to refuse treatment. Although the right to withhold consent is encountered most often by implication in British cases, there is a wealth of American jurisprudence on this matter, validating the claim made here that the right described is dependent on the quality of the information disclosure and not on the outcome, that is it is not definable by the nature of the patient's choice. In cases such as In Re Quackenbush[3] and Superintendent of Belchertown v Saikewicz[4], American courts have explicitly recognised that, although information disclosure may lead to refusal of therapy which is potentially beneficial, the value of the competent person's right to make such choices supersedes the unfortunate consequences of the withholding of consent. As Gostin says:

> Ethically, a patient should be free to make a decision which may be against his medical interests so long as he is able to understand the implication of that decision; the common law places no legal obstacle to a patient's decision to live in great pain or even to risk his life rather than to accept unwanted medical treatment.[5]

Thus, even the apparent irrationality of a given decision is no barrier to the claim that rights should be vindicated. Observance of the patient's right to information about therapy and therapeutic alternatives, it is claimed, far from threatening the doctor/patient relationship could effectively enhance it. Trust between doctor and patient depends not just on the patient's confidence in the doctor but on the doctor's respect for the patient, which necessarily denies the therapeutic imperative in favour of the therapeutic alliance.[6] As Picard points out '... a breakdown in the doctor-patient relationship often occurs when there is little or no communication between the parties.'[7] He reflects ruefully on the causes of a failure in communication which has such serious consequences for what Pellegrino and Thomasma[8] would call a 'good and proper' medical act.

> It is a sad irony that the circumstances of each party militate against clear, thorough communication in a relationship of serious

> consequence. The doctor is likely balancing commitments to other patients, colleagues and committees. His medical education has prepared him to treat the disease but not necessarily the person, and the day-to-day demands on him may make getting to know the patient and his concerns seem impossible or unimportant.[9]

Whatever the reasons, and however understandable they may be, it remains self-evident that the patient's right to information is often minimised or ignored in the current practice of orthodox medicine. This may be explicable but, it has been argued it is nonetheless unjustifiable in the vast majority of cases. Special groups such as children, the mentally ill and the mentally handicapped may require, and have been given,[10] special consideration, but even here it has been shown not only that lack of competence need not be presumed but also that courts in both Britain and the United States have in fact adopted a more ad hoc approach to decision making as to competence, at least in part recognising the importance of the voluntariness of medical intervention. As Gostin argues '... forming categories of people in which the law automatically dispenses with the requirement of seeking consent is fraught with conceptual inconsistencies and practical difficulties.'[11] He concludes that '[t]here can be no greater intrusion on a competent human being than to compel him to receive physicial treatment which he does not want.'[12]

Recognition of the scale of this 'intrusion' demands also that the apparent distinction between the unknowing patient and the unwilling patient is reassessed. Few, if any, would argue for the compulsory imposition of treatment, yet the converse must also be true - that is, that the only therapy which would be argued for is that which is voluntarily undertaken. In other words, acceptable therapy is that which is entered into freely, in knowledge of the possible risks and benefits and with information as to possible alternatives where these exist.

The significance of this right, therefore, is substantial, and the claim that it should be viewed as a Legally recognised and protected interest is, it is claimed, not defeated by the fact that on occasion its realisation may be impossible, for example in extreme cases of mental incapacity or in the case of the very young child who has no method of expressing an opinion. Where therapy is, therefore, selected by others - either parents or otherwise authorised adults - its imposition is, except in rare cases, often justified by the capacity of that therapy to enhance the likelihood of the <u>incapax</u> individual being capable in the future of acting in a self-determing manner. In other words, the ends - of self-determination - may sometimes, albeit unusually, be realised by the use of means which would otherwise be unacceptable. However, recognition that there may be some problematic cases does not detract from the importance of the assertion of self-determination, since the occasions for ignoring the specific aspect of self-determination arise routinely where it is only by so doing that self-determination can be achieved. The primary purpose, in such cases, of asserting the right to information disclosure, incorporating the choice whether or not to accept therapy, is to ensure that the decision as to the competency of an individual patient or decision is made against a background which demands respect for the right, and a correspondingly weighty and compelling justification for its denial.

Mere definition of the right, however, even when combined with justifications for its vindication, is not taken to be a sufficient step. As in the case of many other human rights, emotional or moral appeal does not guarantee respect. Yet if the right is of significance then respect for it must be sought, and failure to respect it must involve the imposition of sanctions and/or the compensation of the person whose right is infringed. In other words, the law must recognise and protect the right by giving it appropriate status in the hierarchy of legitimate interests. Thus, the argument goes on to focus on the methods available to ensure compliance with the terms of the right as described.

Inevitably, since ethical or professional codes are notoriously vague and relatively easy to ignore, proper vindication of the right, and sanctions for its breach, will be the province of the law. As Gregory says:

> It is generally accepted among scholars in

> ethics that the human race, in the course of its cultural development, has described certain 'ideals' of behaviour; one hopes that all would conform to these high standards of behaviour without the need for a 'reward or punishment' scheme. But mankind has become realistic enough to know that, although these standards might be accepted as ideal, they will rarely generate uniform compliance by individuals faced with the mundane, everyday problems of life .... The law steps in in such cases to fill the recognized vacuum .... to assure wherever possible, conformity to the ethical and moral ideal.'[13]

However, in reviewing the attitude of the law to this matter, it is noted ab initio that merely 'stepping in' indicates little about the effect of, or rationale for, legal control. Thus, considerable emphasis has been placed on the nature of the legal remedies available to vindicate this right, since the type of action which legal systems make available has a great impact on the balance of power between pursuer (patient) and defender (physician). This balance is reflected by the nature and type of proof required by the form of action itself and by the capacity for subjectivity in decision-making tribunals, and is measurably related to the value which is placed by these tribunals on the right itself.

Certainly the law recognises the value of autonomy in medicine, otherwise no remedy would be available, but adequate protection demands a form of decision making suited to the issue itself. Thus, it is argued, an appropriate legal response is necessary to the vindication of the right. A number of different actions may be considered appropriate or suitable and their capacity to satisfy patients' rights is analysed in depth. The nature of the available action differs as a result of judicial or state policy, and the impact of these actions on the patient seeking redress for a grievance is thereby affected by the development of the law in respect of compensation in general, and by the preference of a given legal system for certain forms of action. It is claimed, therefore, that it is not merely <u>recognition</u> of an important right or interest which is important, but that the manner in which assertions of abuse are settled has a major impact on the continued significance of rights themselves.

Until relatively recently, actions by patients alleging that they were inadequately informed or risks or alternatives in therapy were competently raised under the general framework of assault.[14] This action has considerable benefits for the patient who need show only that information disclosure fell short of the required standard in order to succeed. However, the action also has many drawbacks, not least that it does not, and cannot, cover cases where the failure to have proper regard for the right involves the provision of no therapy. The terminology of assault is stretched beyond credibility when appealed to in such circumstances. In any event, there is a marked, and understandable, reluctance on the part of the judiciary - and one suspects the general public - to classify medical intervention as an assault, even if this is in fact what it amounts to. This distaste stems from recognition of the value of medical treatment, as well as from a general belief that the intention of the doctor is not to be equated with that which satifies the concept of assault. Connotations of criminal or malicious intent cling to the use of the terminology of assault, and have resulted in its rejection as the appropriate form of action unless the failure to disclose was so gross as to remove the assumption of beneficence and to substitute the presumption of deliberate and aggressive deceit.

The trend, therefore, in most jurisdictions has been to treat a failure to make adequate disclosure as remediable only under the negligence framework, an action which has come to dominate the law of reparation.[15] Whilst this removes some distaste from the picture, the shift to the negligence action - as currently interpreted - has been shown to have numerous disadvantages for the disaffected patient. The action itself ensures that concentration is on doctors' duties and not patients' rights, thus facilitating the importation of professional standards into what is in fact a question of respect for human dignity. Moreover, even where attempts have been made to re-emphasise the rationale which underlies the existence of the right of action, they have consistently fallen short of a vindication of full information disclosure, since negligence analysis, apparently unavoidably, demands that some weight be given to the quality of professional practice.[16] The reluctance of courts to condemn established medical behaviour results in a significant shortfall of success, even where it is admitted that information was not disclosed. Thus, emphasis is placed on the professional justifications for non-disclosure, and the right to information is watered down in the face of competing, but scarcely equivalent, values.

Moreover, the general evidential requirements of the negligence action mean that the patient must demonstrate that he or she was harmed by the alleged breach of duty, a task which will generally be met with failure where the therapy has either not worsened the patient's medical condition, or has provided some relief for it.[17] Inevitably, therefore, the basis of the patient's right is subjugated to the capacity of therapy to improve physical or mental health. By implication, the refusal of therapy takes on the taint of unreasonableness and is thereby disvalued as a self-determining act. A final, and supremely difficult, hurdle faced by the patient in the negligence action is that it is also necessary to convince the court that, had the information been disclosed, therapy would have been rejected.[18] In the light of the fact that this is essentially unproveable, and in view of the presumption in favour of potential relief of ill-health which arises in part from concentration on doctors' duties, the patient is unlikely to succeed.

The nature of the negligence action itself, it is concluded, is apparently antipathetic to the vindication of fundamental rights. This is particularly true when decision makers are impressed by the admittedly high standards of a respected profession and the value of therapeutic intervention. Just as courts are hesitant to admit that non-existence could ever be preferable to existence,[19] so they are reluctant to place a value on continued ill-health, even where freely and knowledgeably chosen, when therapy has the potential to alleviate symptoms or to cure. There are, of course, further problems associated with the negligence action which apply in all cases, not merely those concerning information disclosure in medicine. Most notably, these relate to what has been called the 'forensic lottery'.[20] Lack of certainty bedevils the law in this area. Proceedings are expensive, often protracted and beyond the means of many.[21] Given that, in the case of a patient who was improperly or inadequately informed but who was nonetheless not physically harmed by the therapy, the award of damages in the event of a successful action would be minimal, few will have either the financial or the emotional capacity to undertake the uncertain, expensive and ultimately unsatisfactory task of suing.

Recognition of the shortcomings of the negligence action is growing in relation to all aspects of the search for adequate compensation and protection of important values. Whilst most jurisdictions have seemingly been unable or unwilling to dispense with or modify these problems, some countries have adopted a more radical position in an effort to minimise or obviate them entirely. Both Sweden and New Zealand[22] have instituted alternative systems of liability in order to provide surer and speedier access to compensation. The New Zealand system is the more far-reaching and radical of the two and is therefore singled out for consideration.[23] Many of the allegations which can be made against fault based systems are inapplicable to the Accident Compensation Scheme,[24] but unfortunately the scheme is itself essentially flawed, partly as a result of apparent political timidity. The exclusion of disease from the scheme has been heavily criticised as philosphically inconsistent and practically unjust. Moreover the system cannot in itself avoid the vagaries of interpretation and subjectivity of values unless clear and unequivocal guidance is given as to the meaning to be given to phrases such as 'medical misadventure'.[25]

In fact, the New Zealand system has tended to place the victim of medical misadventure in a situation paradoxically similar to that which many commentators argue is currently the lot of the aggrieved patient in fault based systems. As Mahoney[26] points out:

> The restrictive interpretation which has been placed upon the phrase 'medical misadventure' has resulted in many deserving claimants being excluded from the aegis of the definition of "personal injury by accident"

> and thereby from receipt of compensation under the Act.[27]

He does, however, see some hope for change following judgement of Bisson, J. In MacDonald v The Accident Compensation Corporation,[28] but it is by no means certain that this small inroad will set a pattern for future decision-making. Indeed, cases which preceded MacDonald by only a short space of time have been decided on the basis that '... unless the patient asks the doctor specifically about the risks the doctor is under no obligation to inform the patient.'[29] Moreover, it is likely that the existence of the scheme itself will dissuade a patient who has failed to satisfy the definition of 'personal injury by accident' from seeking to raise an action in the courts, which, although technically possible, is in fact rarely resorted to, either because the public is unaware that a residual right of action remains or because of the impact on the individual of failure under the Accident Compensation Scheme.

The no fault system, therefore, both presents novel problems for the patient who was not informed of risks or options in therapy, and generates its own special ones. Admittedly, not all of the problems are insurmountable in theory, since they can and do depend on the attitudes of decision makers themselves. Others, however, such as the definition of 'accident' are central to the scheme itself and less easily capable of resolution.

What current decision making in New Zealand shares, in particular, with the fault based tradition is an apparent reluctance to award damages in cases where the professional practice of doctors is challenged. This attitude is perhaps more acute in cases dealing with matters of consent, since courts and tribunals may be reluctant to value the abstract rights of patients over the realities of medical intervention which, in some cases, has caused no measurable physical harm, or in others has merely produced harm which is in inherent risk of the therapy itself and is not attributable to inadequate medical care in an operational sense.

In sum, therefore, only the assault based action seems to concentrate on the right of the patient to physical and mental integrity, but it is inherently flawed as a means of generally vindicating the right to information. The other available forms of action, as currently interpreted, are both unsuited to the vindication of rights and fail to distinguish between operational matters (which are genuinely part of the doctors' professional duties) and matters which can be described as relating to the morality of medicine. This confusion results in the failure, perhaps even the inability, of current decision makers to vindicate the right of the patient to information, and the subsequent right to accept or reject therapy.

In all, therefore, it can be concluded that currently used legal methods are unsuited to validation of the right to information disclosure in medicine. The development of the doctrine of 'informed' consent by American courts, seen by some as an attempt to widen the liability of the medical profession,[30] has proved insufficiently weighty or rigorous to defeat the inherent problems of the fault based system. As Tancredi[31] says: '[a]s a legal doctrine, informed consent has hardly fulfilled its promise. It may have created a facade of patient involvement and control, when, in fact, the power still remains with the medical decision-maker.'[32] In New Zealand, as Mahoney[33] points out, the existence of the Accident Compensation Scheme discourages use of the residual right of action, thus effectively providing no incentive for the development of a doctrine of consent based on the patient's right to information.

What, then, if any, are the options available to secure, through legal mechanisms, this important right? Only if the right is accorded overt respect will it be adhered to rather than breached, and only through legal process can redress be obtained where the deterrence of the law has failed. As Shultz[34] says:

> The law is not the only relevant tool for achieving such a relationship between doctor and patient. But ultimately the law is about line-drawing, and some basic division of authority is essential both for purposes of norm-setting and of dispute resolution. The fact that practice, time and complexity will embroider nuance and qualification upon the basic structure does not alter the need for

such a framework.[35]

However, the capacity for change will depend substantially on the jurisdiction concerned, since different legal systems develop and follow distinct legal traditions. The ease with which any jurisdiction is capable of vindicating patients' rights depends on its history and jurisprudence as much as it does on willingness to make appropriate modification or enthusiasm for change. Moreover, the very nature of the health care provided in any state may significantly affect the type and quality of available actions for redress.

In general terms, it can be said that current legal provision for redress, where the interest invaded is the right of the individual to make autonomous choices in health care matters, is at best inadequate and at worst inappropriate to the value of the interest to be protected. A review of assault based actions, negligence based actions and actions based on no fault serves to demonstrate that the interest argued for by this writer is protected, where it is protected, substantially in an indirect fashion, rather than assuming centre-stage in the resolution of disputes. Yet, even under these analyses, its importance is not doubted. Patients should be in a position to avail themselves of professional services without inevitaby rendering themselves vulnerable to denial of autonomy, or to assumptions that the invitation to exercise the professional advisory role automatically assumes a transfer of authority in health care decisions from patient to doctor. Not all of the legal processes outlined above in fact make this presupposition but where they do not (as with assault based actions) other problems render them a less than satisfactory method of interest protection.

Of course, one option not so far considered in detail would be the raising of an action on the basis of the existence of a contract between doctor and patient. In the United Kingdom, cases based on contract have indeed been raised,[36] and it is fair to say that the patient who is involved in private health care may find him/herself with access to significantly improved rights of choice since freedom of choice is central to the nature of a contract. Deceit, fraud or inadequacy of information can render any contract null and void,[37] and the patient is theoretically in no different a position from that of any other contracting party. Further, as the court pointed out in Edgar v Lamont[38] the private nature of an agreement may well provide a remedy in contract but does not deny the existence of delictual or tortious liability. In Thake v Maurice[39] the existence of a private arrangement between doctor and patient was taken at first instance to introduce an implied warranty into the agreement that the service would fulfill the purpose for which it was undertaken, and a failure to indicate that success was not inevitable could then be taken as sufficient to lead to an award of damages.

The fact that an additional protection may be offered by the existence of a contractual agreement, however, serves to emphasise, not the value of the contract itself, but rather the importance to the agreement of information disclosure. Vindication of access to information is facilitated by the nature of a contractual arrangement, but is not generated by it. Since the majority of health care provision in the United Kingdom is undertaken through the National Health Service, the theoretical availability of contractual redress is, however, of limited relevance. In any event, there is no clear rationale for providing legal rules which permit some patients access to vital information, but deny it to others, merely on the grounds of their capacity to pay for the service or on the strength of their ideological or political commitments to health care provision as a whole.

In some jurisdictions, however, the availability of a contractual remedy will have considerably more significance, for example in the United States, where health care is essentially a private agreement between doctor and patient for a fee. However, the availability of contractual remedies depends on the classification made of the event under scrutiny. Issues of professional malpractice in the United States are routinely dealt with on the basis of the negligence action, and if failure to disclose information is perceived as an aspect of professional duties, rather than as a free-standing interest, then the temptation will be to deal with this matter also in terms of professional negligence, as has substantially been the case. As Shultz notes:

> Because patients have been deemed incapable of individual bargaining about expert services, duties undertaken through a contract for professional care have been given content and specificity through negligence policy rather than through contract analysis .... although patients may be incapable of supervising the quality and administration of care, they are capable, indeed uniquely so, of balancing ultimate costs and benefits of care decisions. Moreover, they are capable of determining the extent to which they wish to allocate decision making authority to their doctors. Thus, the rationale for adopting a standardized tort analysis does not extend to issues of decision making and allocation of authority; these matters could appropriately be analyzed under contract doctrine. Were such an approach adopted, the entire analytic paradigm would be reversed. Rather than an invasion of patient choice being one sub-type of injury causation within a professional negligence framework, professionally negligent care would constitute one species of breach of contract.[40]

In Shultz's view, therefore, the use of contract analysis would sharpen the focus on patient's rights or interests, and provide direct protection rather than the rather indirect protection offered by the negligence framework. Furthermore, such a specific form of action would recognise the power of the consumer of health care to dictate specific terms, and prevent the usurpation of authority which is currently common in the doctor/patient relationship. In Shultz's argument, the presumption therefore should be that 'where no explicit term [in the agreement between doctor and patient] is agreed to, patient control of decision-making should be the term implied into the contract.'[41] This, she claims is no significant infringement on the medical professions' role since at this stage their function is to advise and not to determine. Nor does it presume that all patients would wish to exercise this right. Merely it indicates that involvement should be the norm and not the exception. Legal regulation in this way would protect the rights of those who wish to be involved, and, she claims, '[g]iven the tradition of medical paternalism, patients who wish to opt out of such responsibility could easily do so.'[42]

It has been said that in the United Kingdom the contractual remedy has a very limited role to play, and the British patient will in normal circumstances be forced to use tortious or delictual remedies in matters relating to the alleged inadequacy of information disclosure. Thus, much will depend on the extent to which legal change is competent in tort or delict.

Any action which satisfactorily recognises the significance of the right to consent to medical treatment, after adequate and sufficient disclosure of information, and which seeks to provide compensation where breach of this right occurs, must overcome the hurdles already outlined. In fact, the provision of compensation is perhaps of less significance than the symbolic effect of the existence of a right of action. Admittedly, where little practical harm has been caused, little will be anticipated in the way of finanacial restitution. However the rights and interests which patients have are not minimised by the fact that the award of compensation will not necessarily be substantial. As has been said, '[a]n interest is not delegitimated because in a particular instance its invasion produced little demonstrable harm.'[43] Nor is it invalidated because financial compensation is minimal. Personal interests are routinely protected by law, even although the average financial award in personal injury cases remains low.[44]

The harm resulting from the failure adequately to involve the patient in important, and sometimes vital, therapeutic decision-making, whilst not inevitably, or even routinely, resulting in obvious harm, is nonetheless a major infringement of a basic right, toleration of which should not be countenanced by a rights-conscious society. In any event, most developed legal systems protect other intagible rights which broadly equate with the liberty and privacy of the individual.[45] The argument for protection in this area can therefore be equated with the claims of the individual to liberty and privacy in other intimate areas of life. As Shultz, for example, says: '[t]he opportunity for maximum feasible control of medical fate would certainly seem to be as important an interest as control of name or likeness, reputation or seclusion.'[46]

In addition to this evaluation of the interests involved, there remains one further point to be made. Intrusion into the lives of citizens is sometimes made, and generally requires strong justification. However, this intrusion, by means, for example, of restrictions on freedom of speech, is generally undertaken by the state and for reasons which are thought to enhance the general social good by the advancement and vindication of valued rights. Thus, intrusion into the right of freedom of speech can be justified by the impact which non-intervention would have on the rights of other citizens, and by the responsibility which the state has to all of its citizens.

In the case of medical practice, however, and except in situations which concern the control of diseases which threaten society as a whole,[47] the limitation of rights is undertaken by one professional group rather than by the elected representaives of a community, and on grounds and in circumstances which make effective review both of the basis of the practice and of its effect, extremely difficult to achieve.

Yet medical practice is not undertaken in a vacuum, and therapeutic choices involve a number of moral and social factors.[48] Whilst is is accepted that the physician is the more competent to make the clinically appropriate decision, the patient remains the participant who alone can take account of this clinical recommendation, evaluate it, and ultimately make the correct personal decision. The rights and interests to be balanced are both of major significance - that is, professional competence and self-determination - but the latter is argued here to be the more fundamental and wide-ranging of the two. Indeed, an accurate description of the doctor/patient relationship indicates that the doctor's professional standing and competence to act are derivative from, rather than descriptive of, the standing to be accorded to the patient.

Whilst the vindication of rights is not inevitably the province of the law, and given that not all interests are legally protected,[49] it remains nonetheless the case that in situations where professional practice is challenged the most effective mechanism available to the aggrieved party is access to legal redress. In fact, there is no dispute that the law has a concrete interest in matters of information disclosure in medicine - an interest which has resulted from recognition by courts of the potential invasiveness of therapy and the inequalities inherent in professional/client relationships. However, the argument here has been that, whilst recognising the abstract value of patient involvement in therapeutic decision-making, courts have been influenced by a number of other factors into effectively minimising the impact of this principle. Moreover, it is argued, the nature of the legal procedures applied to cases of this sort has proved to be an effective block to the adequate balancing of rights between the parties to the medical act.

The final question, therefore, is whether, accepting the significance of the right here described, the law <u>can</u> be modified to provide a more equitable solution to the problems illustrated in this discussion. The question as to whether or not the law <u>should</u> take account of them is, it is submitted, answered both by the fact that the law already purports to deal with them and therefore clearly regards them as valid objects of legal consideration, and by acceptance of the value of the right to consent to medical treatment, as described here. As has been noted, however, merely to say that the law <u>should</u> deal with these dilemmas is not to identify a mechanism whereby it <u>can</u>. Although a detailed analysis of the possible modifications to legal process is not within the scope of this discussion, a review of some of the possibilities may serve to determine whether or not the assertion of patients' rights to information is a practical possibility in legal process, or merely an idealised and unattainable aspiration.

The possibilities for law reform in this area will, as has been noted <u>supra</u>, depend not merely on a commitment to the ideology of patient self-determination, but also on the nature of the jurisprudence of a given society. Existing attempts to protect patients' rights have been shown to be inadequate, partly because of the essential structures of the available actions and partly as a result of the kinds of decisions taken by courts and tribunals. Two main possibilities, therefore, emerge. First, it may be possible to identify a radical alternative to the forms of redress in contemporary use; second, one might seek to modify the presuppositions of decisions-makers and to emphasis the force of the argument for information disclosure within the most approrpriate existing framework. Although the purpose of this discussion has been to establish and flesh out the nature of a right to consent in medical treament, it may be valuable therefore to consider briefly the options available for its vindication through legal process.

## An Alternative Form of Action?

With the exception of situations where a contract exists between doctor and patient, the possibilities for reform and the provision of an appropriate legal mechanism will arise primarily within the tort/delict framework. Although the Pearson Commission [50] suggested careful and continuing scrutiny of the no fault approach to compensation,[51] it is unlikely ever to become a viable alternative system in the United Kingdom, even if on no other grounds than cost. Moreover, it could be argued that the early introduction of a no fault system would render more difficult the legal vindication of a right to consent, since the scheme offers no incentive for certain types of behavioural reform and minimises, by its very philosophy, the significance of individual rights. Thus, although its theoretical base may be ultimately more satisfying than that currently espoused in most jurisdictions, its potential to satisfy the right as described here is limited.

Thus, it is to reform of the law of tort or delict that attention must be turned if radical alternatives are to be found. As was noted supra, the kind of reform to which communities may reasonably aspire will depend to a considerable extent on the nature of their legal system. Countries which have statements of rights built into their constitution may differ in their approach to recognition of legitimate claims and the methodology for their resolution from those where the legal system is based either on a series of equitable principles or on a strict adherence to judicial precedent. The possibilities for reform may therefore be minimised or enhanced by the ways in which the entire system for redress of grievances has developed.

## The United States

Although the United States is widely regarded as being in the vanguard of the movement for 'informed' consent, examination of judicial attitudes has demonstrated that the emphasis is often placed rather on the apparent acceptance or value of therapy than on the disclosure of information, athough this, in fact, is central to the obtaining of a real consent. Use of the term 'informed' has permitted the judiciary, even in the most apparently radical decisions, to hedge their statements of rights with caveats which correlate professionalism, rationality and reasonableness.[52] Yet the United States Constitution guarantees all citizens fundamental rights which certainly can include freedom from unwarranted or unconsented to medical treatment.

The patient in the United States has the option of using the right of 'privacy' as the basis for an action in respect of unauthorised treatment - a right which is taken seriously in American jurisprudence.[53] Since privacy torts can include both the intentional and the negligent, there may be a way forward in this approach.[54] This will be particularly so where the attitude is taken that the failure to disclose information is not just an infringement of patients' rights but is, very often, a deliberate choice to withhold information and therefore can be encompassed by the concept of intentional rather than negligent tort. The impact of this on the capacity for radical decision-making is evident. If the evidence required is of a deliberate of knowledgeable withholding of information, then the question is clearly centred on the rights of the patient to have the information, thereby avoiding the trap, common in the negligence action, of concentration being focussed on the nature of the duty owed.

Certainly, it seems unlikely that an alternative structure for liability will be generated, but, as Shultz suggests,[55] the deficiencies in the tort based system can be circumvented. Indeed, she continues, '[t]ort analysis could provide adequate protection if patient choice became an independent and fully protected interest in its own right.'[56] Her excellent analysis of consent rules in the United States offers in conclusion a series of proposals for reform which would enhance the position of the patient in relation to information disclosure. These are worthy of consideration since they seem to offer a relatively radical alternative within the existing tort structure.

Most significantly Shultz seeks to restate the nature of the elements in information disclosure leading to the exercise of patient choice. Criticising the emphasis on the nature of the proposed medical act, and in particular the apparent emphasis on the physical invasiveness of therapy, she proposes the creation of a new duty to disclose which would be:

> .... triggered by the possession of information important and relevant to the patient rather than by a proposal to touch. This approach would reverse the relationship between information and choice that is created under current doctrine. At present, the requirement of consent determines the necessity of disclosure. Because, however, choice arises out of and depends upon knowledge and reflection, the essential point of access must be knowledge itself.[57]

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However, like most commentators, Shultz is apparently unwilling to make the final leap and demand <u>full</u> disclosure of information, even where that information might be deemed important by a given patient. In her scheme '.... the duty would not be to disclose all that the doctor knows, but only what is materially relevant to the patient at the time of the disclosure.'[58] Although this statement at first sight seems to differ little from statements made by the court in cases such as <u>Canterbury v Spence</u>,[59] Shultz is prepared to go further and to offer some guidelines in relation to what information is material to the patient, which would effectively limit the unfettered exercise of clinical freedom to withhold information.

In fact, her description of 'material' information demanding disclosure encapsulates many of the legitimate aspirations of patients, and is worthy of repetition here.

> The doctor should affirmatively offer the following information: (1) material clinical observations or test results that describe the condition of the patient at any stage of care; (2) interpretation of this information by the doctor and her advisers, including material judgements and conclusions based on the data; and (3) material possible responses that the patient might elect in light of the information and the possibilities known to the doctor. <u>In each aspect of the duty, "material" must be understood to extend beyond the doctor's certainties."</u> (emphasis added)[60]

Adoption of this approach, particularly given its emphasis on unsolicited information disclosure, would then place the burden of establishing the rightness of non-disclosure firmly on the physician. Of course, apart from the emphasis on the patient's rights to receive information, this may not seem like a particularly radical move away from traditional justifications for non-disclosure. However, there are two main differences. First, justification for non-disclosure would rest only on lack of knowledge or extreme remoteness of risk, and second the test for this justification would be independently set by courts. Shultz's suggestions would demand that the adequacy of disclosure would be tested not against professional practice, but against the protected interest in patient choice. Thus, courts would be free to decide whether or not a patient could make an adequate choice on the basis of the information they received, rather than being forced into an anlysis of the standards of the medical profession. The traditional reluctance to criticise a highly valued professional group would, in this type of analysis, have less significance.

Moreover, Shultz asserts that this approach will facilitate the making of decisions which are relevant to the individual patient, and not simply to the 'prudent' or 'reasonable' patient. Although she concedes that total subjectivity cannot, and will not, be achieved by this scheme, her view is that, even although objective testing may be used, it will be used in the context of essentially personal choices. The court will be enabled to make decisions based on what the particular patient before them would most likely have regarded as significant, in the light of information from and about that patient. Testing the adequacy of information disclosure against both this and a backdrop which recognises a protected interest in patient choice, would, Shultz claims, better serve the legitimate demands of patients.[61]

The essential changes therefore would involve a direct creation of a protectable interest in information disclosure, the testing of challenges against an attitude which combines acceptance of its value with an assessment of the situation of the particular patient, and, in effect, would facilitate a more fact-based approach to the resolution of disputes of this sort. Like the assault based action, proof of non-disclosure would trigger an instant asumption of the probability that a right has been invaded. Unlike the assault based action, however, physical damage is not the cornerstone of the invasion - rather the interest in patient choice is the yardstick, breach of which demands compensation.

Shultz equally justifies this approach against possible objections that patient care will inevitably suffer if such an onerous obligation is placed on the medical profession. On the one hand, she asserts:

> Doctors are universally conceded to be fiduciaries; as such they have special duties to serve their clients' interest.

> Patients have been redefining their interests in the direction of more positive participation in decisionmaking. In the wake of such redefinition, the nature of the fiduciary obligation must also change to stress more advising and less deciding.[62]

On the other hand, to the argument that the health of both individuals and the community will suffer because patients may be distracted from making the 'right' decision as a result of potentially distressing information, Shultz responds from a distinctly consumerist perspective. Noting the complexity of medical decisions, and the rights of individual to decide for themselves, she concludes that:

> The quality of patient choice will, of course, depend on the quality of information provided by the doctor. But assuming adequate performance of that obligation, patient-made decisions should generally yield outcomes that are preferable as evaluted by the ultimate consumer, the patient.[63]

Not all jurisdictions, however, will be in a position to use this type of approach. Whereas the right to privacy has been broadly defined by United States courts, whether or not it is based on a constitutional guarantee, in the jurisdictions of the United Kindom the right is more finely drawn. In any event, the British approach, whilst concerned with protecting important interests, is less prone to using the broad language of human rights to create or to decide on a right of action.[64]

## Scotland

Although some commentators are tempted to assume that Scots and English law are the same, this is an inappropriate and unwarranted assumption.[65] In previous sections, the laws of both countries have generally been dealt with together, partly because a number of the cases taken as authoritative in the United Kingdom as a whole have been Scottish cases, and partly because Scottish Courts will generally regard decisions of the House of Lords as highly persuasive. Thus, the judgement in Sidaway[66] would be likely be taken as a statement of Scots as well as English Law.

However, the distinctions between the two systems may become more crucial when considering the methods by which redress can be sought. It would, therefore, be a mistake to assume that the law in each jurisdiction would necessarily equate, or that apparent agreement on a case necessarily means that the conclusion was reached from the same perspective.

Viscount Stair,[67] the most prestigious of the Scottish institutional writers, in fact adopted a most liberal approach to the situations in which redress could be sought. Indeed, the bases of liability as described by him would be very wide-ranging, permitting appeal to what would currently be referred to as human rights. Thus, his position could broadly be described as being that where there was a wrong there should be a remedy.[68] Working on equitable principles, Scots law has shown on a number of occasions its flexibitity of approach, most notably - in the medico-legal field - when considering the rights of children to sue in respect of damage sustained pre-natally.[69] The law of delict is therefore a potentially wide-ranging and ever-chaging part of Scots law.

From the point of view of the patient, the recognition of a specially protected interest in therapeutic choice based on information disclosure, could be incorporated into a branch of the law which '.... can apply, develop and extend existing principles ....'[70] As with tort, the purpose of the law of delict is essentially to provide an avenue for redressing civil wrongs, as legally defined.[71] This does not, however mean that only these wrongs which have been previously accepted will attract compensation. As Walker says:

> It follows from the purpose and function of the law of delict that this branch of law must constantly be fluid and changing; it must constantly be ready to consider new kinds of losses, or losses caused in new ways, or fresh human claims and interests calling for legal protection, and to decide whether and on what basis and how far to recognise these new claims. The novelty of a claim must never be a complete defence to a claim brought ex delicto, and the state of the law of delict at any given time can represent only the adjustment accepted by the courts at that time and in that social and economic context between conflicting and competing interests, and the consequential decisions on where losses are to fall.[72]

One of the most significant aspects of this statement is the indication that, not only may Scots law accept a novel basis for an action, where the interest to be protected is regarded as sufficiently meritorious in current circumstances, but that it need not be tied to any particular type of action in seeking resolution of the issue. Thus, the fact that negligence predominates in most jurisdictions as the major delict/tort need not tie the hands of the Scottish judiciary. Given the problems identified with the current format of the negligence action, this is good news for patients.

As in most jurisdictions, the conduct which is required to establish delictual liability may be by act or omission (where there is a legal duty to act).[73] Thus, recognition of an obligation to disclose information could ensure that where information is not disclosed, there is evidence of a delict and therefore a remedy becomes available. Of course, if the remedy lies within the negligence framework, at least as currently interpeted, then the patient remains unlikely to succeed. However, alternative forms of action may be available.

In Scots law, one of the oldest forms of action is the actio injuriarum.[74] As McKechnie[75] says, the essential aspect of this action was insult - thus, the classic examples would be assault or defamation. However he concedes that, although the real source of the Scots law of reparation is probably the lex Aquilia, it has become common to refer to the actio injuriarum as incorporating wider types of insult than those described above.[76] Even if, however the action has been confined to assault, for example, at least some of the cases of alleged inadequacy of information could be covered. However, as has been noted, this would not provide a sufficiently radical alternative.

It would seem that - whatever the source - this ancient right of action will now be conceded to include 'wilful aggression on the personality of another ....'[77] Redress may be sought under this action for the insult itself, since '....actual loss or damage is not an essential of actionability, so that an action lies even though no pecuniary loss be proved.'[78] Thus, if this action - which depends on proof of the event rather than proof of fault - is to be a proposed as a competent alternative it is necessary to examine what amounts to 'wilful aggression'.

The dictionary definition of 'wilful' requires that something is 'done intentionally'.[79] In the case of non-disclosure of information, this would incorporate withholding knowledge which is relevant to the protection of the patient's right to self-determination, and of which the doctor is aware. Thus, the doctor could not be liable for failing to disclose information of which he or she is not in possession, athough in some circumstances an action in negligence might arise if the doctor <u>should</u> have known of the information.[80] The doctor who knows information, and chooses not to disclose it for whatever reason, is, logically, acting deliberately, and therefore wilfully, and liability for this behaviour could be encapsulated by the terminology of the actio injuriarum. But can this behaviour also be seen as 'aggression'?

Aggression is generally taken to involve a hostile act, although it need not involve physical violence. If the narrowness of the distinction between the unwilling patient (the imposition of treatment on whom would certainly be seen as aggression) and the unknowing patient, which was highlighted supra,[81] is accepted, then therapy without a real consent is equally an act of aggression. Certainly, it is an attack on the right to self-determination of the individual. Many, however, might seek to equate aggression with the concept of assault, the terminology of which, as has been seen, has largely been eschewed in cases involving an alleged lack of consent. But analysis of the reasons for the shift from assault to negligence would tend to suggest that the rationale was not that an assault is not in fact committed, but rather can be traced to distaste for the use of such value-laden terminology in respect of the practice of medicine.[82]

It can be concluded therefore that Scots law may indeed offer an alternative right of action to that of negligence in such cases. As Walker says:

> The Roman law principles are still the main basis of delictual liability in modern Scots law and have largely superseded indigenous principles ... A person is liable for wilful aggression on the personality of another <u>(injuria)</u>, even though it may not cause pecuniary loss.'[83]

<u>England</u>

The development of the English law of tort is in a somewhat different tradition and results in different conclusions. A general statement of the development of tort law is given by James[84] in these terms:

> Historically, torts are divided into two great classes: <u>trespasses</u> and actions <u>"on the case"</u>. A trespass is a "direct and forcible" injury. This is the most obvious and dramatic of all injuries; it is not, therefore, surprising that in point of time, trespasses were the earliest torts which the law recognized and remedied. Actions "on the case" were actions for damage caused otherwise than "directly and forcibly". They were called actions "on the case" primarily ... because they were originally granted in certain cases where the plaintiff could show that, upon the facts of his case, he had suffered damage as the result of some act or omission of the defendant.[85]

Now, although the infliction of therapy without adequate information disclosure could be seen as both direct and forcible, the strength and implications of the terminology of trespass may provide a strong disincentive to courts' accepting that a trespass has been committed by inadequate information disclosure. Indeed, the English courts have recently indicated that an action in trespass will no longer apply in such cases unless the failure to disclose was gross.[86]

It is from the action "on the case" that other torts such as negligence have developed, with the consequential effect that, whereas in other actions the mere fact of the trespass was sufficient to found a successful action, these other forms of action require evidence of harm. Not only, therefore, will the proof demanded of the litigant include this harm, and evidence that the harm would have been avoided had the information been disclosed, but certain types of harm may not be regarded as legally redressable. As James says: '[i]t must not ... be imagined that, because proof of damage was essential to found an action upon the case, that therefore proof of <u>any sort of</u> damage would, or will, give rise to a claim in tort.'[87]

In his excellent analysis of the law in respect of compensation, Atiyah[88] points to a number of limitations on the right of the individual to claim redress. He notes, for example, that:

> In theory, the courts have ruled out <u>any</u> liability for mental distress which does not arise as a result of physical injury, unless the mental distress manifests itself in some sort of definite illness. Thus, mere grief, anguish, unhappiness, humiliation, outrage and so on, however distressing they may be, are never compensable at all unless they follow on some physical injury.[89]

Therefore, unlike the kinds of harm which may be compensable under the <u>actio injuriarum</u>, it would seem that insult to the person's capacity for self-determination is unlikely to found the basis of a successful claim. In fact this is clear from the fact that the negligence action is currently, and apparently permanently, the preferred action in these cases.

A radical alternative action, therefore, would require to arise either by a restatement of trespass, or from one of the other forms of action "on the case", but it seems unlikely that the latter could be sufficiently modified to accommodate situations where the harm complained of is insult to integrity rather than some physical invasion. In any event, some would claim that the development of English law in this area has been a specific type of process that is, it has been based on the introduction and perpetuation of specific torts.[90] Thus, unlike the approach of Scots law which applies principles in a flexible manner to new situations, English law is said by some to have bound its hands within the confines of nominate torts. This position is equally hotly denied by other commentators,[91] but whatever the truth of the matter, it seems relatively unlikely that a new tort will be developed to take specific account of this intrusion into the rights of the individual.

This is not, however to suggest that the courts cannot expand the categories of redressable harm. However, it is clear that, where a <u>new</u> interest is to be created:

> ...their expansion must, nevertheless, be limited by the practical consideration that not every injury of which people may complain can be regarded as a legal wrong. A tort does not consist simply in the infliction of an injury, but in the infliction of a legally recognized injury.[92]

However, although the limitations on the kinds of injury which can attract compensation may seem at first sight to preclude the patient from any alternative to the negligence based action, there maybe some comfort to be derived from the following: '[f]or the infringement of an absolute right a person is entitled at Common Law to bring an action for damages, although he may not in fact have suffered any loss or inconvenience at all from the act.'[93] Although it is not entirely clear on what basis such claims would be tested, it would seem unlikely that the tests used would be those applied in the negligence based action. Rather they seem likely to be more in line with the tort of trespass. Thus, for the patient, it may be crucial - if alternatives are to be found - that the task of convincing the law that the right to information disclosure is absolute is successfully undertaken, before legal change can be initiated. Whilst the claim in this discussion has been that this right is fundamental, incorporating as it does aspects of self-determination, the current attitudes of the courts would not lead to optimism that such would be their view, particularly if this meant offering novel remedies.

This brief review of the possibilities in three jurisdictions would seem to suggest that existing legal process may, in Scotland and the United States, be capable - without radical revision - of encapsulating and vindicating the rights of patients in respect of information disclosure. The position under English law seems more dubious. In any event, athough all the possibilities canvassed are <u>theoretically</u> plausible, their actual adoption seems somewhat more far-fetched. Yet one further possible option, however, remains.

## Radicalising Decision-Making

Despite the caution expressed above as to the likelihood of legal change resulting from initiatives in process, the position of the aggrieved patient need not be hopeless. Although current decision making may seem to block the potential for a real recognition both of the value of the right and the validity of the claim for redress, the question remains as to whether or not reform is yet possible. In terms of the systems currently operating, rather than those alternatives briefly discussed above, the assault based action has been shown to be insufficiently wide ranging to encompass a right whose definition is not dependent on physical intrusion but rather on the intangible concepts of self-determination, liberty and privacy. For this reason it will not be re-considered here.

However both of the other major schemes of liability no fault and negligence) merit some reconsideration in order to assess the extent to which radicalised decision-making would enhance their capacity to protect this important right.

It has been said of the no fault system, as currently operated in New Zealand, that it neither offers protection to the patient who alleges 'medical misadventure' nor does it provide an incentive for changes in medical practice.[94] As Mahoney notes:

> The effect ... of the present interpretation of the 'medical misadventure' style of 'personal injury by accident' is blatantly ironic. Except in the unusual case of equipment failure or a bizarre and novel reaction to treatment, the person who suffers a personal injury from medical treatment must prove fault in the nature of 'old style' medical negligence if he hopes to receive compensation. If he cannot meet this requirement then he is denied assistance from a system that purports to have as its philosophical underpinning the abolition of the elusive search for fault.[95]

Inded, it is clear from cases such as Re Munday[96] and Re Stopford[97] that the only risks which will, if they occur, generate compensation under the scheme are very remote risks indeed. Indeed, in at least one case, the judge has been prepared to say '[i]t seems clear that unless the patient asks the doctor specifically about the risks the doctor is under no obligation to inform the patient ...'[98]

In fact, of course, although the exclusion of illness from the accident compensation scheme has proved to be one of the biggest stumbling blocks to the operation of the system in a way which equates directly with its philosophy, the attitude of decision-makers has served to refine it further. Many of the presuppositions and attitudes which informed the pre-existing tort based system have simply been carried through to the new scheme.[99] However, this is neither unavoidable nor inevitable. The crucial factor to be borne in mind in respect of this system is that the interpretation presently common in 'medical misadventure' claims is not derivative from, nor defined by, the terms of the legislation itself. Specifically in relation to matters of information disclosure as has already been seen, the current attitude can, in fact, be said to be in direct contrast to the ideological underpinnings of the definition of accident outlined by the Woodhouse Report, [100] and incorporated into the legislation.

Although not a simple task, some of the essential flaws in this radical system, at least in respect of information disclosure, can be overcome. Acceptance of the basic right to information, held by every patient in vindication of their self-determination, when combined with the given definition of accident, could be sufficient to encourage decision makers to give allegations of non-disclosure serious and unequivocal consideration. However, one fatal flaw remains, and this is one which does relate to the very nature of the scheme itself.

The type of compensation envisaged by the scheme is considerably different from that awarded in tort based systems. The accident compensation scheme was designed essentially (although there are exceptions) to cushion loss rather than to recognise the existence of a wrong where that wrong had caused no pecuniary loss. Compensation, therefore, is assessed on the basis of needs, and is closely tied to assisting where there is a loss of wages. In this respect, like the tort based system, compensation requires evidence of that loss. Mere insult will not suffice unless it results in damage which can be described as a 'personal injury by accident.'[101] Thus, although the scheme may become more flexible, damages sought in relation to non-disclosure of information, where the only damage is the insult to integrity, can only be sought through recourse to the civil courts.

Thus, the patient will continue to face the same obstructions to redress which are faced by his or her equivalent in other jurisdictions. Moreover, the New Zealand patient seems for the moment to be somewhat reluctant to proceed this far. Mahoney explains this reluctance thus:

> The very existence of the Accident

> Compensation Act must have a negative effect on the public's recognition of the possibility of these claims. A public that has been told for a decade that the drunk driver and the rapist are immune from civil suit can hardly be expected to learn by osmosis from a few legal journals the possibility of suing a doctor where medical treatment does not turn out as expected or promised.'[102]

The pattern of decision-making demonstrated in the no fault system is, it has been claimed, essentially similar to that which prevails in the negligence action. Cautious decision-making is equally a feature of this latter action. Where balancing is undertaken, courts have tended to presume the 'good' of therapy in preference to what is described here as the 'good' of patient self-determination. Thus, they are reluctant to impute fault to a benign and socially valued discipline, whose motivation is generally conceded to be good, even although, '[s]ince motive, as a rule, finds no place in the Law of Torts, a good motive can no more redeem than a bad motive can condemn.'[103] This is no less true of the law of delict.

However, this approach need not be immutable. Recognition of the importance of the right here described can result in its legal protection. The value attributed to each of these 'goods' can be weighted to take account of the distinction between questions concerning professional competence and those which relate to fundamental rights. However, it has also been suggested that the emphasis, inherent in the negligence action, on the concept of duty, can provide, and presently does create, an almost insurmountable obstacle to direct concentration on the rights of patients. If the negligence action is to be of value in such cases clearly this hurdle must be overcome. It is here that the true radicalisation of decision-making would be required since to date '... the duty of care concept has largely been used for the purpose of resricting liability for cases of proved fault, rather than as a means of expanding liability ....'[104] But is this inevitable?

There are, in fact, two methods whereby modification could be introduced to the concept of duty of care and in favour of the protections of patients' rights. Both require redefinition of the duty, but in slightly different ways. First since the duty of the doctor, and his or her justification for intervention, derive from the rights of patients, the duty of care concept could be clearly defined as including the duty to disclose risks and benefits of therapy. As was noted above,[105] merely to talk of a duty of care says nothing about the content of that duty, and a commitment to the right of a patient to make a self-determining choice could result in the fleshing out of the duty to take account of this. In principle, legal or practical, there is no obvious barrier to such a move. Thus, the decision as to whether or not a doctor had been negligent would, amongst other things, be dependent on the fact of whether or not certain information had been disclosed. In other words, failure to make disclosure would, in itself, be negligent.

A second option would be similar to that which Lord Scarman sought to describe in the Sidaway[106] case - that is, the separation of purely professional and more generally moral duties, which are recognised and reinforced by legal backing. Thus, questions as to the adequacy of information disclosure would be matters to be judged without direct reference to professional practice. Rather, assessment would hinge on the extent to which disclosure would enhance or protect the fundamental rights of the patient. Given acceptance by the judiciary of the value of the right and the need to protect it, such an approach could avoid the traps fallen into by current theoretical positions which:

> .... submerge analysis of the interest in autonomy within the related but divergent framework of redress for professional incompetence .... Protection of patient autonomy remains derivative rather than direct, episodic rather than systematic. As a result, significant harms to patients' interest in choice go unredressed.'[107]

The effect of either of these options would be to shift the decisional balance towards the right of the patient, but although they have certain similarities, their results in terms of legal process would not be identical. The former proposal would equate more closely with Shultz's[108] proposed creation of a new protected interest, by making a definite statement of patients' rights, breach of which would be actionably negligent. The second would essentially minimise the negligence concept by permitting the courts to award compensation where the behaviour is deemed not be appropriate or good, rather than only where it is negligent.

Either of these options, however would have the value of ensuring attention to patient autonomy, but would they satisfy the third element of negligence, that is the occurrence of foreseeable harm? If invasions of the right to information disclosure are taken as culpable, then failure to make this disclosure can scarcely be said not to result in consequences which are foreseeable, that is the invasion of the right. However, although foreseeability may present no formidable obstacles, the legal definition of 'harm' may.

It has been said already that Scots law has long recognised the right to receive compensation where no pecuniary or physical loss is demonstrated. A straight translation of this into the negligence action does not seem beyond the bounds of possibility, and would therefore prove to be no barrier to the assessment that harm has been caused. Recognition of, and compensation for, the insult to the individual consequent on failure to disclose information is consistent with the tradition of Scots law. Equally, although it may be that English law has developed in a slightly more restrictive way, nonetheless defining the concept of 'harm' to include invasion of a basic right does not seem out of the question.

It can be seen, therefore, that although much criticised, negligence analysis - surprisingly, perhaps, even more than the no fault system - may have the capacity to reflect patients' rights more than it currently does. The responsibility for making the necessary changes rests firmly with the judiciary, who must be convinced that the interest which it is claimed has been invaded is significant, and that failure to respect it does occasion legally recognised harm. The attitudes of courts of law, it is argued, continue to play a role in the protection of individual rights through the laws of tort or delict, even although the strength of their contribution may have been reduced. Atiyah may be right to argue that the administration of law in this area:

> ...rests not in the hands of barristers and judges (whatever they may think), but in the hands of certain employees of insurance companies, and the way in which these gentlemen behave is often just as important, if not more important, than the way people behave in law courts.[109]

However, this does not by itself imply that the decisions of courts are irrelevant, nor that their ideology will not have an impact on others who are involved in reaching compensation decisions.

## Conclusions

The preceeding section has considered, albeit briefly and somewhat superficially, the possibilities for legal change or modification. A more detailed analysis is beyond the scope of this discussion, which has rather been concerned to establish three fundamental hypotheses. First that the language of rights can legitimately be used in analysis of the doctor/patient relationship; second that the fundamental right to self-determination incorporates the right of the patient to consent, or not, to medical treatment on the basis of adequate information disclosure; and third, that legal attitudes and process play a highly significant role in the vindications of this right.

The last section was designed, moreover to demonstrate that this right is no mere unattainable, academic aspiration. The fact that mechanisms _can_ be found which facilitate its vindication lend weight to demands for its routine implementation. Further, it is hoped that the fleshing out of the concept itself will be taken as guidance for, and not criticism of, the medical profession.

Analysis of the complex and important values which characterise the patient's involvement with medicine has reinforced the view that medicine is not a value free discipline. Important issues of personal integrity are intimately tied up with the decision whether or not to participate in a medical act. Equally, it is a mistake to view questions of consent in medicine solely from the perspective of legal requirements about capacity to consent, or as in some sense generated or defined by medical criteria. The issue, therefore, has been expressed in the language of human rights in order to disentangle it from the current anaytical framework, which fails to make an adequate distinction between the separable issues of patients' rights and professional competence. Just as patients' status is enhanced by this shift in emphasis, so doctors are not threatened by it. The aim of medical practitioners should be, and generally is, not just a professionally competent act but also a morally appropriate one.

To achieve this latter, however, they too require an ethical basis from which to assess their activities. It has been suggested that one possible source of this is reference to what those with decision-making powers have to say about given practices. Thus, the approach of the law to this problem has considerable significance, not just in redressing grievances but in setting consistent and unequivocal standards to which doctors may address themselves. Compliance with these standards renders doctors less vulnerable to legal action or patient dissatisfaction.

It is claimed here, therefore, that a right to consent can be identified, encapsulating the right to withhold consent. But concentration on the methods by which consent is or can be, demonstrated, which is common in current discussions of this area, serves to disguise the true nature of the question. What is crucial is not whether a patient seems to have consented (or not) but whether or not his or her apparent decision was based on an adequate disclosure of information, so that actions can truly by described as the product of a real or meaningful choice. The right to consent, therefore is essentially described by emphasising the right of information disclosure, and the right to use that information in a manner which is personally satisfactory. It can be seen, however, that without legal reform, insufficient attention will be paid to the need for this disclosure.

What is needed, therefore, is an assertion of the values inherent in the doctor/patient relationship and redefinition of their respective roles. For the moment, questions of autonomy do not predominate, or even feature very significantly, in the legal assessment of a medical act. However, it has also been suggested that this position is not immutable. Change may occur, either through modifying the relevant legal process or by influencing decision-makers. In a rights-conscious society, the sporadic and equivocal protection of patient's rights can no longer be tolerated, and a new formula for the allocation of responsibility in medicine is urgently required. Giving serious weight to the proposition discussed here will, it is hoped, provide a relevant starting point for the development of a morally appropriate allocation of power within medical practice.

In this discussion, the writer has sought to establish that there is a value in viewing the interaction between patient and doctor in terms of basic rights - in particular a right to informtaion disclosure, leading to the capacity to protect the capacity of the patient for self-determination, has been identified and described. However, it is further argued that, even accepting the existence of this right, its vindication depends substantially on its legal recognition. Further, effective recognition is essential, and thus, it is suggested, the law must both acknowledge the validity of the right, and provide an effective mechanism whereby its breach or invasion can be remedied. In this way, a proper balancing of the rights and interests concerned in the practice of medicine can be established, and the legitimacy of the patient's interests in his or her health care accepted. A review of the existing legal mechanisms would suggest that the potential for change exists, given a rights dominated approach to the issue.

## NOTES

1. for further discussion, see chapter 5, <u>supra.</u>
2. 70 N.J. 10 (1976)

3. 156 N.J. Super 181 (1978); the court in this case permitted an elderly patient with a good prognosis to refuse life-saving therapy.

4. 370 N.E. 2d 417 (1977); the court held that the common law right to bodily integrity and the constitutional right to privacy protected a competent person's right to refuse medical treatment. For further discussion, see Davis, S.M. 'The Refusal of Life Saving Medical Treatment vs. the State's Interest in the Preservation of Life: a Clarification of the Interests at Stake' 58 Wash. U.L.Q. 85, at p. 101: 'The right to bodily integrity involves the right to make decisons affecting one's body but also reflects a concern for avoidance of pain and indignity. Many believe that much of modern technology strips the patient of all human dignity, and that when treatment offers no real benefit a patient should not be subjected to it. Conscious but incompetent patients should be able to avoid medical treatment that causes pain or indignity without countervailing benefit. Although unconscious patients sense neither pain nor indignity, the right to bodily integrity should also extend to them, to protect competent persons' interests in assurance of proper treatment should they become incompetent.; see also, Jackson, D.L., and Younger, S., 'Patient Autonomy and

"Death with Dignity": Some Clinical Caveats' The New England Journal of Medicine, Vol. 301, 404 (1979).

5. Gostin, L.O., 'Compulsory Treatment in Psychiatry: some reflections on self-determination, patient competency and professional expertise' 7 Poly Law Review, 86 (1982), at p. 86.

6. c.f. Teff, H., 'Consent to Medical Procedures, Paternalism, Self Determination or Therapeutic Alliance' 101 L.Q.R. 432 (1985); Calman, K.C. and McLean, S.A.M., 'Consent, Dissent, Cement' Vol 29, No. 4, Scottish Medical Journal, 209 (1984)

7. Picard, E., 'Consent to Medical Treatment in Canada' 19 Osgoode Hall Law Journal 140 (1981), at p. 140.

8. Pellegrino, E., and Thomasma, D., A Philosophical Basis of Medical Practice, Oxford, O.U.P., 1981.

9. loc.cit., at pp. 140-141.

10. see chapter 8, supra.

11. loc.cit., at p. 86.

12. loc.cit., at p. 89

13. Gregory, D.R., 'Informed Consent: An Overview' 9 Legal Aspects of Medical Practice, 4 (1981), at p. 4

14. for discussion, see chapter 3, supra.

15. Weir, T., A Casebook on Tort, (5th. Ed.), London, Sweet & Maxwell, 1983, at p. 267: 'It was barely

fifty years ago that the tort of negligence was born, or synthesised, but it has thrived so mightily and grown so lusty that one could be forgiven for wondering whether there was room left for any other tort at all.'

16. since the essence of the negligence action is the concept of 'duty of care'; for further discussion, see chapter 4, <u>supra.</u>

17. see chapters 5 and 6, <u>supra.</u>

18. see particularly chapter 6, <u>supra.</u>

19. <u>McKay</u> v. <u>Essex A.H.A.</u> [1982] 2 W.L.R. 890; for discussion of the problems in 'wrongful life' actions, see e.g. Liu, A.N.C., 'Wrongful Life: Some of the Problems' 1987 <u>J. Med. Ethics</u> 69; Symmons, C.R., 'Policy Factors in Actions for Wrongful Birth' <u>M.L.R.</u> 269 (1987)

20. Ison, T.G., <u>The Forensic Lottery</u>, London, Staples Press, 1967.

21. even despite the availability of legal aid; for recent discussion, see 'The Independent' 17 March 1987, under the headline 'How to remove financial insult from injury'.

22. for further discussion, see <u>Report of the Royal Commission on Civil Liability and Compensation for Personal Injury</u> (Pearson Commission) Cmnd 7054/1978.

23. see chapter 7, <u>supra.</u>

24. now governed by consolidating legislation in the

Accident Compensation Act 1982.

25. for further discussion of these interpretational problems, see chapter 7, supra.; see also Mahoney, R., 'Informed Consent and Breach of the Medical Contract to Achieve a Particular Result: Opportunities for New Zealand's Latent Personal Injury Litigators to Peek out of the Accident Comoensation Closet' 6 Otago Law Review, no. 1, 103 (1985); McLean, S.A.M., 'Liability Without Fault - The New Zealand Experience' [1985] J.S.W.L. 125.

26. loc.cit.

27. at p. 105.

28. Unreported, High Court, Adminstrative Division, Hamilton, 25 July, 1985, 55/85, discussed by Mahoney, loc.cit.

29. Re Priestly [1984] N.Z.A.C.R. 787, per Willis, J., at p. 789.

30. e.g. Robertson, G., 'Informed Consent to Medical Treatment' 97 L.Q.R. 102 (1981).

31. Tancredi, L., 'Competency for Informed Consent: Conceptual Limits of Empirical Data' 5 International J. of Law and Psychiatry, 51, (1982)

32. at p. 51.

33. loc.cit., particularly at p. 137.

34. Shultz, M.M., 'From Informed Consent to Patient Choice: A New Protected Interest' 95 Yale Law Journal, 219 (1985).

35. at p. 299

36. e.g. _Thake_ v. _Maurice_ [1984] 2 All E.R. 513, but see also [1986] 1 All E.R. 497; _Eyre_ v. _Measday_ [1986] 1 All E.R. 488.

37. for discussion of contractual obligations see Walker, D.M., _The Law of Delict in Scotland_, (2nd Ed., revised), Edinburgh, W. Green & Son Ltd., 1981; Weir, _op.cit._

38. 1914 S.C. 277

39. _supra cit._

40. _loc.cit._, at p. 281

41. at p. 282

42. _id._

43. Shultz, _loc.cit._, at p. 291.

44. for discussion, see Pearson Commission, _supra cit._

45. for analysis of a range of rights, many of which are intangible, e.g. the right to freedom of speech, see Campbell, et al., (eds) _Human Rights: From Rhetoric to Reality_, Oxford, Basil Blackwell, 1986.

46. _loc.cit._, at p. 278.

47. Thus, societies may infringe, on classical utilitarian lines, certain liberties if their exercise threatens others, in line with J.S. Mill's classic statement 'On Liberty' 6 (1873) '...the sole end for which mankind are warranted...in interfering with the liberty of action of any of their number, is

self-protection...the only part of the conduct of any one, for which he is amenable to society, is that which concerns others.'

48. c.f. Illich, I., Limits to Medicine. Medical Nemesis: The Expropriation of Health, Harmondsworth, Penguin Books, 1985 edition; Kennedy, I., The Unmasking of Medicine, London, George Allen & Unwin, 1981; Shultz, loc.cit.

49. c.f. Walker, op.cit.; Rogers, W.V.H., Winfield and Jolowicz on Tort, (12th. Ed.), London, Sweet & Maxwell, 1984.

50. supra cit.

51. para 1371

52. for further discussion, see chapter 5, supra.

53. even although the Constitution makes no specific reference to a privacy right, the use of the concept is common in both American courts and American academic writing.

54. c.f Shultz, loc.cit., at p. 283: 'Privacy torts encompass both negligent and intentional conduct without being confined to one or the other, and this approach would also be appropriate for patient choice.'

55. loc.cit.

56. at p. 283.

57. at pp. 283-284.

58. at p. 284.

59. 464 F 2d 772 (1972)

60. *loc.cit.*, at pp. 284-285.

61. *loc.cit.*, at p. 286 *et seq.*

62. at p. 279.

63. *loc.cit.*, at pp. 292-293

64. see chapter 6, *supra*; Campbell, *et al.*, *op.cit.*

65. c.f. Walker, *op.cit.*, at p. 30: '...new kinds of torts have been, and may again be, recognised, but any such general proinciple as of liability for fault is open to many qualifications and objections. With a totally different history, and with modern cases still sometimes determined by historical factors, it can never be assumed that an English case apparently in point is a safe guide in a Scottish court, or that because the two systems reach the same or similar conclusions on a given set of facts, the underlying principles are the same.'

66. *Sidaway* v. *Board of Governors, Bethlem Royal Hospital* [1985] 1 All E.R. 643 (H.L.)

67. Stair, *Institutions of the Law of Scotland*, (2nd. Ed.)) University Presses of Edinburgh and Glasgow, 1981 (Edition by Walker, D.M.)

68. for a general exposition of Stair's perspective, see Inst. I.1.

69. for discussion, see McLean, S.A.M., 'Ante-Natal Injuries' in McLean, S.A.M., (ed), *Legal Issues in Medicine*, Aldershot, Gower, 1981.

70. Walker, *op.cit.*, at p. 29.

71. c.f. *Winfield and Jolowicz on Tort*, *supra cit.*

72. *op.cit.*, at p. 30.

73. c.f. Walker, *op.cit.*

74. for discussion, see Walker, *op.cit.*, at p. 20: '*Injuria* seems originally to have covered any wilful aggression of one individual on the person of another which did not cause any actual or material harm. Later it acquired the meaning of an actionable offence against the individual's personality, his person, dignity or reputation.'

75. McKechnie, H., 'Delict and Quasi-Delict' in *An Introduction to Scottish Legal History*, Edinburgh, The Stair Society, 1958.

76. *id.*

77. Walker, *op.cit.*, at p. 20.

78. Walker, *op.cit.*, at p. 40.

79. Chambers Twentieth Century Dictionary.

80. for further discussion, see chapter 4, *supra.*

81. see chapter 2, *supra.*

82. see chapter 3, *supra.*

83. Walker, *op.cit.*, at p. 31.

84. James, P.S., *Introduction to English Law*, (5th Ed.), London, Butterworths, 1962.

85. *op.cit.*, at p. 292.

86. *Chatterton* v. *Gerson & Anor.* [1981] 1 All E.R. 257.

87. *op.cit.*, at p. 293.

88. Atiyah, P.S., *Accidents, Compensation and the Law*, (3rd. Ed.), London, Weidenfeld and Nicolson, 1980

(reprinted 1984)

89. at p. 82.

90. this has been a long-standing debate; c.f. Williams, G., 'The Foundation of Tortious Liability' (1939) _7_ _Camb. L.J._ 111; Winfield, 'The Foundation of Liability in Tort' (1927) _27_ _Col. L. Rev._ 3.

91. Williams, _loc.cit._, proposes a compromise, at p.131: 'Why should we not settle the argument by saying simply that there are some general rules creating liability...and some equally general rules exempting from liability...Between the two is a stretch of disputed territory, with the courts as an unbiased boundary commission.'

92. James, _op.cit._, at p. 294.

93. _Stephen's Commentaries on the Laws of England_, (21st Ed.), Vol II, London, Butterworths, 1950.

94. see chapter 7, _supra._

95. _loc.cit._, at p. 107.

96. [1984] 4 N.Z.A.R. 339.

97. [1984] N.Z.A.C.R. 783.

98. _Re Priestly_, _supra cit._

99. see chapter 7, _supra._

100. _Report of the Royal Commission of Inquiry on Compensation for Personal Injuries in New Zealand_, (Government Printer, New Zealand) (1967).

101. for discussion, see chapter 7, _supra_

102. _loc.cit._, at p. 137.

103. *Stephen's Commentaries*, *supra cit.*, at p. 280.

104. Atiyah, *op.cit.*, at p. 38.

105. see chapter 4, *supra.*

106. *supra cit.*

107. Shultz, *loc.cit.*, at pp. 298-299.

108. *loc.cit.*

109. Atiyah, *op.cit.*, at p. 7.

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