PATIENT PARTICIPATION IN MEDICAL DECISION-MAKING:

ARE THE COURTS THE ANSWER?

By
Brian Bromberger*

As with other relationships, the rights and obligations imposed upon medical practitioners and patients have been determined by recourse to traditional common law principles. The increasing sophistication of both parties has stretched the flexibility of the common law to breaking point and produced decisions which do the law no credit. The following demonstrates how the judicial response to patient demand for a role in medical decision-making is an example of this inadequacy.

Over the past two decades much has been written about the desirability of patients becoming more involved in their own case management.[1] The reasons given for this transition from passive reliance on medical advice to active participation in the treatment process are numerous and, while they may make sense individually and appear logical, they are difficult to verify empirically.

It has been suggested[2] that the demystification of the medical art and the emergence of medicine as a science has enabled the general population, or at least a substantial portion of it, to become more aware of the various functions of the human body. Television, the popular press and the more sophisticated journals have spent an

* LL.B. (Hons.) (Melb.); LL.M. (Penn.); Senior Lecturer in Law, University of New South Wales.

1 *E.g.*, Frankel, "Medico-Legal Communication" (1976) 6 *Willamette L. J.* 193, 222. The author concluded, inter alia, that there was a need that physicians give:
(i) greater attention to the non-medical causes of malpractice actions;
(ii) care for and thorough forewarning of the potential risks to the patient;
(iii) assurance that consent is understandably and willingly given;
(iv) attention to the patients' fears and worries;
(v) more attention to "patient-physician relationship".

2 Mechanic, "Some Social Aspects of the Medical Malpractice Dilemma" in The Duke Law Journal Symposium, *Medical Malpractice* (1977) 1.

enormous amount of time attempting to reduce complex medical concepts to a level which enables the general population to participate in the learning. Since 1945 there has been a considerable increase in the number of children remaining at school past the age of fourteen. Universities have increased their intake accordingly. Not only does this improve the general level of education of the community but an examination of most high school curricula reveals that practically all students are taught much of the basic functioning of the human body. This general demystification process is not restricted to the activities of the medical profession. "Do it yourself" divorce, conveyancing, will-writing and debt collection intrude into an area never before confidently visited by the general public and to a large extent this is contrary to the wishes of its guardian, the legal profession at large.

While detailed consultation and advice between the parties has been an integral part of the normal professional-client relationship elsewhere, it has been slow to surface in the medical profession. It is probably the dream of every architect to receive an instruction from a client which gives him *carte blanche* to produce that which he thinks most suitable for the client's needs. At the same time it would be considered a breach of ethics for a lawyer to withhold information from a client on a matter relating to a particular case, for example, the offer of a settlement, on the basis that the client could achieve a more favourable result by adopting another course which happens to be preferred by the lawyer.[3] Such a situation has not been, and is not necessarily now, an integral part of the traditional practice of medicine; movements that have suggested change have met with limited co-operation.[4] This would appear to be so even though there is an increasing body of literature which suggests that patient participation in medical decision-making is in fact good medicine.[5]

In an area filled with considerable controversy there is some incontrovertible data. The medical practitioner of 1983 is faced with a totally different set of circumstances than was his colleague of 1883. The Royal Medical adviser who ordered the postponement of the coronation of Edward VII in order that he have his appendix removed was not armed with an array of antibiotic drugs which may have made the operation unnecessary at all, or at least ensured that an appendectomy was the most appropriate procedure. This same array of drugs has changed the old equation — child under ten + sore throat + "running nose" = tonsillectomy — to a course of treatment that makes the operation only one of a number of possible alternatives. Just as medical science has increased the options open to a medical practitioner in the medical treatment of previously treatable complaints so medical science has developed procedures which can offer relief or cure to patients suffering from formerly untreatable complaints. The past few decades have seen the emergence, and in some instances the abandonment, of procedures, which were thought to provide hope where there was previously little to offer. Ice pick surgery was responsible for many thousand

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3 *Marsden* v. *Marsden* [1972] 2 All E.R. 1162.

4 Many physicians find intellectual difficulty with the concept that not only does the patient have the right to participate in and control the ultimate medical decision but the patient has the right to make the 'wrong medical' decision.
James E. Ludlam, *Informed Consent* (1978) 2.

5 E. S. Glass, "Restructuring Informed Consent: Legal Therapy For the Doctor Patient Relationship" (1970) 79 *Yale L. J.* 1533.

operations in the 1940's[6] and lobotomy and leucotomy gave way to amygdolotomy in an attempt to find remedies for previously untreatable conditions.[7] The development of the catheter, radio-therapy, and chemo-therapy have all contributed considerably to medical science but at the same time the development of many sophisiticated procedures have often brought with them attendant risks. The subsequent and inevitable question to be asked by both patient and doctor is: "Is the problem as it is, more desirable than the possible remedy with its attendant risk?"

To a considerable extent, while medical science has been extending its array of weapons, the general public have been fascinated onlookers. With the discovery of each "medical miracle" the press has celebrated with banner headlines.[8] This, no doubt, has caused an unrealistic anticipation by these interested onlookers of unlimited expertise and inevitable success in all that is undertaken. It has been suggested that because of this unrealistic expectation, any subsequent failure brings with it unprecedented anger.[9]

It has also been suggested[10] that it is a combination of these factors which have led to an increase in patient demand for active participation in medical decision-making. Unfortunately, this is usually made after the occurrence of a bad medical result and in the context of court proceedings. This has the effect of changing the circumstances of the demand from that of professional evolution to professional liability. This in turn has meant that the patient demand for participation is being claimed as a remedy through the courts with the result that the parameters of these "rights" are being necessarily dictated by recourse to general common law principles.[11] The direct result of this process is a jurisdictionally diverse body of law which purports to dictate to medical practitioners and health personnel generally, the extent to which they must "receive instructions" from their patients and sets out the legal consequences for failure to act within these guidelines. This area of the law has the tautological name of informed consent.[12]

The main problem which must be squarely faced is whether or not the court room is the place from where edicts will come which will result in medical practitioners as a body changing their modes of behaviour to fit in with the change of both their clientele and their armoury.

At the outset it should be acknowledged that this general aspect of medical treatment is not clinical but ethical, and as such, goes much deeper into the heart of professional independence and autonomy than those aspects which may be termed clinical. In fact, where legal actions have located a flaw in medical procedure, the medical profession has been quick to respond in a way designed to eliminate the flaw. An example of this can be seen by the way in which the author of a standard textbook

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6 E. Cunningham Dax, "History of Prefrontal Leucotomy" in J. Sydney Smith and L. G. Kiloh (eds), *Psychosurgery and Society* (1977) 19.

7 *Ibid.*

8 *E.g.*, "Babies without pregnancy — That's Life in 2013" *Sydney Morning Herald*, 24 May 1983, 1.

9 Mechanic, note 2 *supra.*

10 *Ibid.*

11 But *cf.* Mental Health Act 1958 (N.S.W.) s. 108(2).

12 The Compact Oxford Dictionary defines consent as "voluntary agreement" and "unity of purpose". It is submitted that there can be no "unity of purpose" unless the parties to the "unity" are informed as to the "purpose".

in spinal anaesthetic responded to the findings of fact in *Roe* v *Minister of Health.*[13] Even though the plaintiff in this case was unsuccessful it was revealed in the course of the case that there was danger in the storage of fluids in glass ampoules when the ampoules were stored in antiseptic fluids. This was because there was a chance that invisible microscopic cracks caused by knocking might occur in the glass. The case began in 1949 and was finally determined in 1954. The standard text on spinal anaesthetic written in 1973 states: "Never place solutions in alcohol, spirit or antiseptics of any sort. This dangerous practice has been dealt with extensively in a previous edition of this book".[14]

However, the medical profession seems to resent any intrusion by the law into areas of medical practice regarded by them as sacrosanct. Irrespective of technical knowledge or competence, medical practitioners have adhered meticulously to the principle of patient confidentiality, so much so that considerable resistance is encountered when, because of a perceived social need, the law attempts to break down this ethical principle. When the battered baby syndrome was first discovered it was hoped that medical practitioners would be encouraged to report to the relevant authorities instances of this rather horrendous happening.[15]

Awareness of the general attitude towards patients and the belief in the security of any communications received from them by members of the medical profession prompted the New South Wales government to pass legislation[16] designed to overcome this reticence. Protection from legal consequences was specifically given to any doctor who reported instances to the authorities in good faith. Yet even now, those in the best position to discover the problem have been shown to be the "worst" reporters.[17]

If the corresponding desired standards of consultation are to come about as a result of judicial proceedings, it is necessary to ascertain whether or not the courts have been successful in the past in altering methods of behaviour, as distinct from altering medical methodology, through the imposition on medical practitioners of judicial remedies. It is true that the common law courts have been active over the past few years in formulating a body of law in this area. This has been so even though there has been some considerable judicial resistance to the use of the most obvious common law remedy in this area, that of assault.[18] This is probably due to the fact that there is a subconscious resistance by the courts against finding that there has been an assault on the patient by the doctor when the motive for the action giving rise to the case is honourable in that the sole purpose of the treatment was the belief by the doctor that the treatment would benefit the patient.[19] In fact, it is submitted that the reason why the courts have at times moved from holding that there has been an assault arising out of a medical practitioner's failure to disclose relevant information and therefore acting

13 [1954] 2 Q.B. 66.

14 MacIntosh and Lee, *Lumbar Puncture and Spinal Analgesia* (3rd ed. 1973) 165-66; see also Thornton and Levy, *Techniques of Anaesthesia* (2nd ed. 1981) 46.

15 Child Welfare Act 1939 (N.S.W.) s. 148B(6) gives "protection" to a "prescribed person" who reports incidents of child abuse to the Director.

16 *Ibid.*

17 *Ibid.* See also V. Montana, *Somewhere a Child is Crying — Maltreatment — Causes and Prevention* (1973).

18 *F.* v. *R.* (1983) 106 L.S.J.S. 136; *Reibl* v. *Hughes* (1981) 114 D.L.R. 3d 1.

19 *Hart* v. *Herron,* unreported, Supreme Court of N.S.W., 10 July 1980, 48 *per* Fisher J.

without the patient's consent, to holding that these actions will lie in negligence for unreasonably withholding information[20] is motivated by this feeling of sympathy. This is especially so when such a shift enables the matter to be determined by reference to the activities of the reasonable medical practitioner, as demonstrated by what other medical practitioners are doing, as distinct from that which the reasonable patient would have expected. Even so, cases have decided the following: when no consent is necessary;[21] how much information about treatment must be volunteered by the medical practitioner;[22] what alternatives should be presented;[23] how the medical practitioner should respond to specific questions;[24] whether there is a difference between general consent and specific consent[25] such that a lack of the former gives rise to an action in assault whereas lack of the latter gives rise to an action in negligence; what are the parameters of implied consent;[26] whether the whole problem should be viewed through the eyes of the reasonable doctor, the reasonable patient or the particular patient;[27] the extent to which parents may override the requests of children for treatment;[28] how much authority can be delegated by parents and guardians to those in control of or simply supervising children[29] and to what extent may society order treatment to any groups deemed to be a risk;[30] whether there is a distinction between experimental medicine and therapeutic medicine[31] and how hospital consent forms should be interpreted.[32]

Lest it be thought that the imposition of a duty to disclose relevant medical information to patients will stultify medical practice and remove some vital aspects of medical decision-making from the medical profession, it is necessary to examine some specific instances. In *Male* v. *Hopmans*,[33] the plaintiff patient complained that Dr Hopmans had made a decision to adopt a particular course of treatment without consulting Mr Male. Mr Male was suffering from a badly infected knee which if left untreated would have endangered his life.[34] The medical practitioner was "given permission" to treat but failed to disclose to the patient that there were in fact three alternatives open to him: to operate, to treat with an antibiotic wash, or to increase the dose of suitable drugs in order to speed up the healing process. While it is submitted that Dr Hopmans should have been under an obligation to disclose to Mr Male the

20 *Reibl* v. *Hughes*, note 18 *supra*.
21 *E.g.*, in an emergency: *Murray* v. *McMurchy* [1949] 2 D.L.R. 442.
22 *F.* v. *R.*, note 18 *supra*.
23 *Ibid. Cf. Bang* v. *Charles T. Miller Hospital* 88 N.W. 2d 186 (1958).
24 *Smith* v. *Auckland Hospital Board* [1965] N.Z.L.R. 191.
25 *Male* v. *Hopmans* (1967) 64 D.L.R. 2d 105.
26 *Hart* v. *Herron*, note 19 *supra*, 39.
27 *Reibl* v. *Hughes*, note 18 *supra*.
28 *K.* v. *Minister for Youth and Community Services* [1982] 1 N.S.W.L.R. 311.
29 P. D. G. Skegg, "Consent to Medical Procedures on Minors" (1973) 36 *Mod. L. R.* 370.
30 *K.* v. *Minister for Youth and Community Services*, note 28 *supra*.
31 *Halushka* v. *University of Saskatchewan* (1966) 53 D.L.R. 2d 436.
32 *Rogers* v. *Lumbermen's Mutual Casualty Co.* 119 So. 2d 649 (1960).
33 Note 25 *supra*.
34 At the time when Mr Male was admitted to hospital his temperature was 104°F, his sedimentation rate very elevated, and his white cell count in four days had risen from 9,300 to 11,300. Had the infection not been brought under control, the knee joint would have been destroyed, in all likelihood the bone surrounding the knee joint would have become involved and osteomyelitis develop and more remotely the infection might have spread to other parts of the body, with or without such spreading causing death, *id.*, 107.

consequences of the various choices open to him — surgery resulting in a permanently stiff leg and antibiotic treatment effecting a complete cure — disclosure could not be expected to go to the possible consequences of Dr Hopmans' negligence. Having decided to increase the dosage of neomycin but to restrict it to acceptable limits, Dr Hopmans nevertheless failed to adopt accepted procedures which would have protected Mr Male from known dangers inherent in the treatment.[35] To impose upon a medical practitioner the obligation to disclose possible consequences of his own negligence is not to enforce any concept of patient participation but rather to introduce some measure of strict liability and insurance into an area which neither needs it nor wishes it.

It may be expected that as a result of these judicial pronouncements medical practitioners would modify their behaviour if it were at variance with that expounded by the courts as necessary in order that the risk of liability to the patient be removed. Furthermore, this should take place as an inevitable result of a judicial proceeding. While it is unfashionable to speak of the law of torts in any context other than that of a vehicle for obtaining compensation for damage suffered[36] there are those who would insist that judicial findings in this area of the law act as a method of regulating behaviour. Glanville Williams has argued that Austin was correct when he said[37] "the proximate end of the civil sanction . . . is redress to the imposed party; but its remote and paramount end is the same as that of the criminal sanction; the prevention of offences generally".[38] If such were the case one would expect to discover a change of *modus operandi* as a consequence of legal activity and, if not a change in the way the practice of medicine was carried out, at least an acknowledgement of the fact that there is a correct way[39] even if on an individual basis some decide to reject it. This, however, has not been the case. The American experience seems to indicate little such change in traditional methods even though the extent of legal activity in the medical area is many times greater in that country than in Australia.[40] As might be expected in the light of the foregoing, there appears to have been no noticeable change in Australia. Hospitals are continuing to use the same ubiquitous consent form that they have used for over forty years. From this form they obtain much comfort even though

35 Contraindications of the drug were included in each package with instructions that when continuous treatment was being provided an audiogram should be taken at regular intervals, *id.*, 110.

36 "Recent legislative and judicial developments show that the criterion of liability in tort is not so much culpability but on whom should the risk fall" *per* Lord Denning in *White* v. *White* cited in J. G. Fleming, *The Law of Torts* (5th ed. 1977) 10, n. 35.

37 Glanville Williams, "Aims of the Law of Tort" (1951) *Current Legal Problems* 137, 144.

38 *Ibid.*

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> It is fundamentally important that the physician-patient relationships rest upon a basis of mutual confidence. The honest, competent, conscientious physician should have some assurance that as long as he is doing a competent job he is not going to be harassed by litigation, subject to unpleasant notoriety, and forced to spend much of his time in court trying to keep from being penalized. The doctor is entitled to have patients in whom he may safely have confidence.

L. L. Regan, *Doctor and Patient and the Law* (3rd ed. 1956).

40 Indemnity insurance which is the ultimate yardstick of the risk has risen to $200 per annum in N.S.W. whereas in the U.S.A. it has risen enormously so that in California in 1970 an orthopaedic surgeon could expect to pay premiums of up to $30,000 per annum: see Brook, Brutocco & Williams, "Medical Malpractice and Quality of Care" in The Duke Law Journal Symposium, *Medical Malpractice*, note 2 *supra*, 20.

by *any test* it is of limited value.[41] Yet while there has been no obvious change of procedure there has certainly been an increase in awareness of the fact that there are

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41 CONSENT TO ANAESTHETICS OPERATION AND OTHER TREATMENT

CONSENT BY PATIENT

I, ...

of ....

hereby consent to undergo the operation ....

the effect and nature of which have been explained to me by

Dr ....

and to such further or alternative operative measures as may be found to be necessary during or as a consequence of such operation.

I also consent to the administration of anaesthetics for these purposes.

I understand that an assurance has not been given that the operation will be performed by a particular surgeon.

DATED this .... day of .... 19 ....

(Signed) ....

(Witness) ....

This form gives no explanation of the effect and the nature of the operation and as such would be of little value where what was explained was at issue.

Compare this type of form with that used in *Kammowitz* v. *Department of Mental Health* (Civil No. 73 — 19434 — A. W. (Cir. Ct. Wayne County), Appendix I to B. Bromberger, "Psychosurgery and the Law in the U.S.A." in J. Sydney Smith and L. G. Kiloh (eds), note 6 *supra,* 137, 140:

> Since conventional treatment efforts over a period of several years have not enabled me to control my outbursts of rage and anti-social behaviour, I submit an application to be a subject in a research project which may offer me a form of effective therapy. This therapy is based upon the idea that episodes of anti-social rage and sexuality might be triggered by a disturbance in certain portions of my brain. I understand that in order to be certain a significant brain disturbance exists, which might relate to my anti-social behaviour, an initial operation will have to be performed. This procedure consists of placing fine wires into my brain, which will record the electrical activity from those structures which play a part in anger and sexuality. These electrical waves can then be studied to determine the presence of an abnormality.
>
> In addition, electrical stimulation with weak currents passed through these wires will be done in order to find out if one or several points in the brain can trigger my episodes of violence or unlawful sexuality. In other words this stimulation may cause me to want to commit an aggressive or sexual act. I understand that the investigators will destroy this part of my brain. I agree that it should be surgically removed, if the doctors determine that it can be done so, without risk of side effects. Should the electrical activity from the parts of my brain into which the wires have been placed reveal that there is no significant abnormality the wires will simply be withdrawn.
>
> I realise that any operation on the brain carries a number of risks which may be slight, but could be potentially serious. These risks include infection, bleeding, temporary or permanent weakness or paralysis of one or more of my arms or legs, difficulties with speech and thinking, as well as the ability to feel, touch, pain and temperature. Under extraordinary circumstances, it is also possible that I might not survive the operation.
>
> Fully aware of the risks detailed in the paragraph above, I authorise the physicians of Lafayette Clinic and Providence Hospital to perform the procedures as outlined above.

legal requirements imposed on those practising medicine.[42] It is submitted that the very reason why there has been no change caused by the proclamation of the law by the courts in this area is the fact that those who are supposed to be regulated by the law of torts respond in exactly the same way to that which they regard as ill-conceived tort law as the general population responds to that which is perceived as ill-considered criminal law. In Glanville Williams' terms, it is an indisputable fact that although torts and criminal law have taken divergent paths they both have common origins.[43] Typical of this has been the effect of the changing mores of society regarding the obedience to, and the enforcement of, "victimless crimes". If one of the aims of the criminal law is to ensure that the general body of the population orders its life in such a way as to cause minimum disruption to others and therefore to the state, then one would expect those activities labelled criminal to reflect this aim.[44] It is when the general population sees that such is not the case that the activities labelled criminal are either ignored by the population or not enforced by the law enforcement officers. It is irrelevant whether or not the proscribed activity had its origin in the common law or in legislation.[45] What is more, if for some reason a generally unenforced law is revived in a specific instance there is inevitably a cry of foul play and moves for its abolition which are often abandoned after the single instance of its use has passed from notice.[46]

The changing public attitudes towards such offences as prostitution, homosexuality, gambling, obscenity and pornography, and indecent exposure have resulted in either positive action by legislators[47] or in "positive" inaction by law enforcement agencies.[48] While it is impossible to prove empirically, the case is certainly strong for the assertion that an attempt to regulate these activities by prohibiting them was doomed to failure because those who were being regulated refused to accept either the wisdom or the purpose of the regulation. Recent experience tends to verify this thesis by proof of the reverse. Statistics reveal that a large percentage of motor car accidents are attributable to driving skills being impaired by the driver's consumption of excess quantities of alcohol.[49] The New South Wales Parliament passed legislation which enabled the police to stop any motorist at any time without any prior indication of incompetence, and apply a breath test.[50] At the time of the passing of the legislation there was considerable concern expressed about the violation of human rights that such

42 Since 1977 the writer has delivered approximately 200 lectures to medical practitioners, health administrators and paramedical workers.
43 Glanville Williams, note 37 *supra,* 137.
44 *Quaere* whether the laws relating to gambling in N.S.W. reflect the community's attitude towards it.
45 *E.g.,* the acceptance of "topless" bathing, and the reported spread of S.P. bookmaking.
46 *Shaw* v. *D.P.P.* [1962] A.C. 220.
47 *E.g.,* the amendments to the Lotteries & Art Unions Act 1958 (N.S.W.) in 1975 and 1980.
48 Since *R.* v. *Wald* (1971) 3 D.C.R. (N.S.W.) 25 there has not been one prosecution for abortion even though the case does not permit abortion on demand.
49 45% of drivers killed had a blood alcohol content of *at least 0.05%:* N.S.W. Minister for Transport, the Hon. P. Cox in his second reading speech on the Motor Traffic (Road Safety) Bill, *Hansard,* 24 November 1982, 2966.
50 Motor Traffic (Road Safety) Amendment Act 1982 (N.S.W.).

legislation would facilitate. Civil rights groups fumed,[51] lawyers protested,[52] and the liquor lobby shouted.[53] Almost immediately road fatalities dropped by over 30% and at the time of writing, some three months after its introduction, statisticians are confidently saying that approximately two hundred people are presently alive who would not be "but for" the passing of the legislation. Civil rights groups have ceased their protest, lawyers have been silent and the liquor lobby has changed its stance from total objection to a rather baleful plea that the legal limit should be raised from .05 to .08.[54] However, it is almost certain that if the road toll rises again cries will be heard for the abolition of the law on the grounds of its ineffectiveness.[55]

Undoubtedly, medical practitioners are concerned to carry out their various tasks in ways which they perceive will be in the best interests of the patients. But when the medical practitioner's perception of the patient's best interest is at variance with the law's determination of the patient's legal rights then it is submitted that the two are on an inevitable collision course. That this is the situation can be seen by an examination of three well-known cases occurring some twenty years apart. In *Murray* v. *McMurchy*[56] Dr Murray, in his defence asserted the following: there was a chance that the fibroid cysts which he had discovered in Mrs McMurchy's uterus were malignant; that good medical practice demanded they had to be removed; that any subsequent pregnancy would increase the likelihood of the recurrence of the cysts and consequently increase the likelihood of malignancy; that it is better for a patient to have one anaesthetic rather than two; that the removal of the cysts had so badly scarred the uterine wall that the pressure on it from any further pregnancy might cause it to tear and thus endanger the life of Mrs McMurchy; that his experience, over some twenty years of medical practice, indicated that this type of problem was invariably solved by the medical practitioner rather than the patient, if not totally independently of the patient, then certainly after the patient had subsequently asked: "What do you recommend doctor?"[57] It is obvious that Dr Murray was of the opinion that he had taken the correct course of action because later, when he disclosed to Mrs McMurchy that he had tied her fallopian tubes, he was in a position to suggest to her that such an action was absolutely medically necessary. This would have removed the likelihood of any subsequent challenge to his decision.[58]

When Dr Windsor said to Mr Smith:[59] "Don't worry old chap; we'll give you a general anaesthetic, you won't know anything about it and you will be home again in three days", there is no doubt that he was both trying to allay any fears that Mr Smith

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51 "Random Breath Tests Will Hit Workers" Letters, *Sydney Morning Herald*, 1 November 1982; "Cox Lobbies MP's to Adopt Breath Tests" *Sydney Morning Herald*, November 1982, 3; "Friendship is Forgotten in Breath Test Debate" *Sydney Morning Herald*, 3 November 1982, 6; "Laws Adequate" Letters, *Sydney Morning Herald*, 9 November 1982; "Clubs & Pubs Pull the Blinds" *Sun-Herald*, 14 November 1982, 11; "Bad Driving the Real Villian" Letters, *Sydney Morning Herald*, 23 November 1982.

52 *Ibid.*

53 *Ibid.*

54 *Ibid.*

55 *Daily Mirror*, 4 April 1983, 1.

56 Note 21 *supra*.

57 *Ibid.*

58 This is so because "emergency" is a defence to assault: *Murray* v. *McMurchy*, note 21 *supra*.

59 *Smith* v. *Auckland Hospital Board*, note 24 *supra*.

might have about the risk of the procedure while at the same time, he was trying to encourage Mr Smith to agree to have a series of tests which were indicated, in order that Mr Smith's condition could be properly assessed and treated. Once again the opportunity was open for the doctor to suggest some relevant variation to this set of words but he elected to "tell the truth".

It is clear that both these doctors saw the obtaining of the optimum medical result as the main justification for their professional existence and as such were both no doubt surprised and disappointed when they found that their perception of their professional *raison d'être* was being frustrated by the law. The assumption made by medical practitioners that their decision-making power overrides any *need* to involve patients in their decision is often shown in strange ways. A Sydney surgeon was recently criticised, under the umbrella of parliamentary privilege, by the New South Wales Minister for Health, Mr Laurie Brereton.[60] He was accused of over-servicing patients because on the same day he removed the tonsils of six juvenile members of the same family. In an article in *Medical Practice,*[61] a well-known and highly respected journalist[62] recounted the details of the incident along with an interview with the doctor. Apparently, the family concerned belonged to the Jehovah Witness branch of the Christian Church and, as such, the parents disclosed to the doctor that they would withhold permission to proceed with the treatment if the removal of the tonsils could only be carried out safely if permission was given for recourse to a blood transfusion. The parents had attempted to get a number of surgeons to remove their children's tonsils but when told of the precondition with regard to blood transfusions they had refused. When told of the precondition the surgeon in question nevertheless agreed to proceed with the treatment. In his interview with the press the surgeon explained that even though he was aware of the reason why the parents had brought the children to him — "[a]s far as I was concerned, it meant she did not want a blood transfusion to be given" — he nevertheless said he had "an answer up his sleeve" because he was familiar with the New South Wales legislation[63] which empowered medical practitioners to override parental objections to the administration of necessary blood transfusions to minor children.

"There is no way I would have let one of her children die, . . . there was no point in upsetting her further about it, because she was already pretty apprehensive".[64] This aspect of the case received no public comment at all even though it would seem to be a classic example of the failure of a medical practitioner to involve the patient[65] in the decision-making process especially as that element of the procedure which the doctor had "up his sleeve" went to the heart of the question and was the only reason that the particular medical practitioner was consulted at all. Furthermore, the openness of the medical practitioner concerned indicates that *he* did not consider, when faced with the need to remove the tonsils, that this key issue should be left to, or even discussed with,

60 "Attack Under Privilege" *Medical Practice* (January 1983) 31.

61 *Ibid.*

62 Shaun McIlraith was presented with a special award for journalism by the Australian Medical Association.

63 Public Health Act 1902 (N.S.W.) s. 39B.

64 Note 60 *supra,* 36.

65 As the children were minors, consent for the treatment had to be obtained from the parents.

the parent of the patients. In the light of standard hospital procedure with which the surgeon was undoubtedly familiar, it would be impossible for him to have been unaware that there was a need for parental consent[66] but as with other "laws" which purport to regulate behaviour, unless those to be regulated accept the wisdom of the regulation, those acts or omissions which form the subject of the regulation will not be affected.

It is of some concern that some members of the bench do not see the regulatory effect of the law in this area as being relevant. The moment the court reduces the determination of liability to a simple determination of compensation to be paid, the rationale for the complexity of a trial fades into insignificance. It is submitted that the reduction of a seventy day trial to a bottom line of "it is all about money"[67] is to deny one of the basic aims of the law of torts.

It is clear from these examples that patient participation is viewed by the medical profession and the judges as primarily an ethical question to be answered in the terms dictated by the medical profession rather than in terms dictated by outside forces and in *Hatcher* v. *Black*[68] the court went so far as to assert that the amount of information that should be given to a patient is to be determined by the doctor's conscience.

What is more, those who would respond to the preceding argument by pointing to the fatuous doctrine of fault liability are met with a dilemma because if disclosure to patients will produce better medicine then it is not the compensation for any damage but the fault of non-disclosure of a fact which is the relevant issue and this would not be revealed in the context of a claim made in the traditional no-fault system.

Also, it is often the case that the patient's complaint is that there was no information given to him about *known* risks of the treatment. In these circumstances when the bad result occurs it can never be regarded as an accident and as such would not be compensable under most presently operating no-fault schemes.[69]

The possibility that the catheter which Dr Windsor[70] inserted into the arm of Mr Smith would cause the subsequent damage that it did was well-known to medical pratitioners and the injury suffered by Mr Smith could not be described as an accident within the terms of any no-fault compensation scheme operating at present. Similarly, the risk of damage to the patient in *Reibl* v. *Hughes*[71] was both known and likely, and once again this predictable result could not be described as an accident.

It is common ground that treatment without patient consent is assault.

> He does not claim that anybody came up and punched him, but it is not necessary for him to claim what I call that old fashioned sort of violence . . .[72] Here the allegation is that a man received treatment which involved the physical handling of him without his consent and the assault therefore would be the giving of medication, the giving of E.C.T., and the incidental handling of him for those purposes.[73]

66 See the "effect and nature" clause in the consent form, note 41 *supra.*
67 *Hart* v. *Herron,* note 19 *supra,* 15.
68 *The Times,* 2 July 1954.
69 This has necessitated the inclusion of ss 65-68 of the Accident Compensation Act 1972 (N.Z.) wherein compensation is available for certain occupational injuries and diseases which would, by their very nature, fall outside any definition of accident.
70 The medical practitioner who was involved in *Smith* v. *Auckland Hospital Board,* note 24 *supra.*
71 Note 18 *supra.*
72 *Hart* v. *Herron,* note 19 *supra,* 41 *per* Fisher J.
73 *Ibid.*

But it is surprising that the courts have had such difficulty in the application of what are submitted to be rather simple questions, especially when they have often asserted that when an *emergency* arises consent is not necessary.[74] This of course removes from the argument any claim that a requirement of patient participation will endanger the life of the patient.

This reticence becomes more apparent when it is demonstrated that the word "consent" is by no means new to the law. Criminal law and the law of contract have found it necessary to define this word and have done so without any apparent difficulty.

> The relationship of principal and agent can only be established by the consent of the principal and the agent. They will be held to have consented if they have agreed to what amounts in law to such a relationship even if they do not recognise it themselves and even if they have professed to disclaim it, as in Ex parte Delhasse. But the consent must have been given by each of them, either expressly or by implication from their words and conduct. Primarily one looks to what they said and did at the time of the alleged creation of the agency. Earlier words and conduct may afford evidence of a course of dealing in existence at that time and may be taken into account more generally as historical background. Later words and conduct may have some bearing, though likely to be less important.[75]

Moreover, when the courts have been shown to be either unable or unwilling to provide an adequate solution to the problem that parties do not have an equal amount of knowledge the various legislatures have been prepared to fill the breach.[76] It is trite to assert that there can be no contract unless there is consent between the parties that such is to be the case, and, in reality, much of the doctrines of mistake and misrepresentation centre around the knowledge of the facts possessed by the contracting parties, even though the courts have been hesitant to impose an affirmative obligation to disclose relevant information on a party in possession of it.

"There being no fiduciary relation between the vendor and purchaser in the negotiation the purchaser is not bound to disclose any fact exclusively within his knowledge which might reasonably be expected to influence the price of the subject being sold."[77] The adverse social consequences of this potential inequality between contracting parties have been repeatedly asserted[78] and acted upon. The protection given to those who purchase from door-to-door salesmen,[79] those who purchase second-hand cars from motor dealers[80] and the protective provisions of the Contracts Review Act 1980 (N.S.W.) were not spawned in a vacuum but are clear examples of the general awareness of the problems which arise when one party to a contract has information relevant to the basic formation of the contract which the other party does not have.

While the medical profession as a whole might be offended to see a comparison drawn between the practice of their profession and the crass commercialism of the law

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74 *Murray* v. *McMurchy*, note 21 *supra*.

75 *Garnac Grain Co. Inc.* v. *H.M.F. Faure and Fairclough* [1968] A.C. 1130, 1137 *per* Lord Pearson.

76 *E.g.*, Crimes (Sexual Assault) Amendment Act 1981 (N.S.W.)

77 *Turner* v. *Green* [1895] 2 Ch. 205, 209 citing *Walters* v. *Morgan* (1866) 3 D.F. & J. 718.

78 Contracts Review Act 1980 (N.S.W.).

79 Door-to-Door Sales Act 1967 (N.S.W.).

80 Motor Dealers Act 1974 (N.S.W.).

of contract, there is no doubt that, as between doctor and patient, a contract for the provision of professional services exists. Furthermore, it is most unlikely that they would deny that a special relationship exists between a medical practitioner and his patient. Trust, faith, confidentiality, and absolute integrity are the words which purport to set the ethical standards of the profession but, in a contractual sense, far from imposing a less stringent obligation to disclose relevant information, this position of trust and reliance imposes a higher duty. In fact, where a contract is between parties and a special relationship of trust exists between them, there is a duty on each of the parties to disclose any fact exclusively within his knowledge which might reasonably be expected to influence.[81]

In *Johnson* v. *Buttress*[82] Mr Justice Dixon (as he then was) asserted that where one party has authority or influence there must be clear evidence that the judgment of the potentially influenced party was free and based on information as full as that available to the other party. Furthermore, the relationship between a doctor and his patient satisfies this requirement.[83] It might be thought that the basis of the special obligations imposed on fiduciaries is to ensure that there is no conflict of interests between the fiduciary and *cestui que trust.* Even if this be the case, the obligation imposed upon medical practitioners to disclose will not be affected because the giving of information relevant to the formulation of the contract will affect any decision whether or not to proceed with the suggested treatment — and thus pay the fee — or even to continue to be the doctor's patient at all.[84]

It would be a matter of some considerable regret if the relationship between a medical practitioner and patient were reduced to that of the vendor and purchaser of a used motor car; yet it would appear that the courts and legislatures have been prepared to give more protection, in terms of decision-making, to the purchaser of a second-hand vehicle from a doctor, than to an individual patient about to have major surgery who has no access to the mass of relevant information, and wishes to be involved in the decision-making process.

But in an appropriate fact situation a plaintiff may be better served bringing an action in contract rather than tort. Those cases which have raised contractual issues have inevitably failed because the claim was made in terms of breach of warranty rather than that of a breach of a fiduciary's duty to disclose.[85] In *Hatcher* v. *Black*[86] the plaintiff consented to an operation which would remedy a toxic goitre. Prior to the operation the surgeon had mentioned to the patient that there was an alternative method of treatment which would not require surgery. In so doing he had failed to inform the patient that there was an inherent risk in the surgery not present in the alternative procedure. When the predictable, but not negligently caused, bad result occurred, the plaintiff alleged negligence. It is submitted that had the damaged plaintiff

81 *Turner* v. *Green,* note 77 *supra.*

82 (1936) 56 C.L.R. 113.

83 *Id.,* 134.

84 *E.g.,* the refusal by the plaintiff in any one of such cases as *Reibl* v. *Hughes,* note 13 *supra*, *Hart* v. *Herron,* note 19 *supra* and *F.* v. *R.*, note 18 *supra* to accept the alternative decided upon by the medical practitioner would have had the effect of denying the medical practitioner the fee for the procedure, and, necessarily transferring the patient to another specialist.

85 *F.* v. *R.* note 18 *supra.*

86 Note 68 *supra.*

brought the action in contract on the basis that the defendant doctor, a fiduciary, had failed to disclose relevant information exclusively within his knowledge, and that the failure to disclose had induced the plaintiff to enter into a contract which was likely to cause her damage, she would have succeeded. Surely, to conclude that success or failure in instances such as the above should depend upon whether or not the action was brought in contract or tort is to resurrect the past so that the old forms of action continue to clank their chains with a resounding rattle.

It is true that any patient may ask for information but the obligation on a fiduciary transcends this and incorporates an obligation to voluntarily disclose, bearing in mind that in the doctor-patient relationship it is unlikely that the patient will know enough even to ask the most appropriate questions.[87]

Again, even the criminal law, in which failure to comply with legal strictures carries with it much more than an obligation to perform a contract or pay compensation for failure to perform, has not shied away from imposing an obligation to inform where the consent is necessary. Consent to sexual intercourse is negated and the offence of rape is committed unless there is knowledge of the "nature of the act".[88] This imposes the obligation to disclose and explain on the party who has the knowledge and who is aware of the lack of knowledge of the other.

It must surely be a matter for some comment that information given by a medical practitioner and therefore patient participation, has been treated by the courts in a totally different way from that outlined above. There is no doubt that in any doctor-patient relationship it is the medical practitioner who is possessed of all the relevant information. There is no doubt that the patient is almost entirely dependent on the disclosure by the doctor of this information in order to arrive at a decision whether or not to comply with the suggested course of treatment. It is further submitted that because of the general dissemination of medical information to the public there is a greater need for the specifics of any case to be explained to the patient as the maxim that "a little knowledge is dangerous" is not without merit.

A recent case in South Australia further demonstrates the difficulties which arise when consent is treated as being divisible. In *F.* v. *R.*[89] a female who had had three children by caesarian section approached her medical practitioner in order to prevent further pregnancies. The medical practitioner suggested a tubal ligation and the patient agreed. At the time of the consultation the patient's husband enquired about the necessity of his having a vasectomy, but the doctor explained that as his wife was being sterilised this would not be necessary. The operation was subsequently performed in a perfectly satisfactory manner but a process called recanalisation occurred and the patient became pregnant again.

It was revealed at the trial that in 0.5% of cases recanalisation will occur without there being any fault in the performance of the operation and that this fact was not revealed to the patient [or her husband]. The patient claimed that the non-disclosure of the possibility of the failure of the operation vitiated her consent thus giving rise to an action in assault and in the alternative, that the failure to disclose the information

87 It is this very fact which makes the terms of the standard consent form inappropriate.
88 *Papadimitropoulos* v. *R.* (1957) 98 C.L.R. 249.
89 Note 18 *supra.*

constituted negligence. At trial[90] the court rejected the claim that the consent was vitiated but upheld the claim that the failure to disclose constituted negligence. On appeal, the Full Court of the South Australian Supreme Court held that the failure to disclose the information that there was a 0.5% risk of failure did not amount to negligence. While admitting that in previous cases [and claiming that they were moving away from this trend] there had been something of an abandonment by the courts of a patient's "right to self determination", in the face of adherence to the view that "current medical practice" should be determinative, the result could be nothing if not a reinforcement of the latter. The effect of the case was the holding that absent a specific request for information, there is no absolute duty on a medical practitioner to disclose information and that an international figure of 0.5% must be viewed in the light of the doctor's personal success rate. The doctor had performed six hundred operations and this was the first such incident.

The fact that the husband suggested to the medical practitioner that he would have a vasectomy in order to reduce the risk of further pregnancy, together with the fact that this was rejected by the doctor as unnecessary because the wife was being sterilised did not, in the court's opinion, amount to a specific request for information about the possibility of failure. Absent a completely artificial requirement that a precise form of words be used, it is hard to imagine a course of events which demonstrates greater patient interest in the ultimate outcome of a procedure. Not only did the court use this spurious argument to distinguish the facts of the instant case from that of *Smith* v. *Auckland Hospital*[91] but in holding that the success rate of the individual medical practitioner is determinative, it ignored the vital point in *Smith's* case that even though the medical practitioner in that case had neither never seen the "bad result" nor heard of it happening in a New Zealand hospital it was a *known* risk and should have been disclosed. Furthermore, the acceptance by the court that six hundred successes in an area where there is a predicted 0.5% failure rate is in some way evidence of the excellence of the practitioner is to totally misconceive the meaning of this statistic. In fact, as 0.5% represents one failure in two hundred cases, one would expect approximately 20% of those carrying out this procedure to have a success rate of one failure in six hundred or even better and this without any need to classify any individual practitioner as possessing superior skill.[92]

It is submitted that it is precisely because the courts have treated disclosure issues as involving the tort of negligence, that they have found themselves arriving at decisions which are logically indefensible and conceptually misplaced. The facts of *F.* v. *R.*[93] are not in dispute. A patient and her husband seek out the advice of a medical practitioner.

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90 *F.* v. *R.* [1982] S.A.S.R. 437.

91 Note 24 *supra.*

92 The figure presented in the case was expressed as a range of 1-0.5%. I have deliberately based my argument on the 0.5% rate because this figure is most favourable to the medical practitioner and therefore the court's reasonings. However, if the figure of 1% is used, then while fewer practitioners would expect to have a success rate of one failure in six hundred, the obligation to disclose would seem to be higher. *Quaere* if the world average showed a 50% failure rate, would a medical practitioner who had no failure in six hundred operations be relieved of the obligation to disclose? — author's conversation with A. L. Tyree Ph.D. (Math) (Massey); LL.B. (VUW); Senior Lecturer in Law, University of New South Wales.

93 Note 18 *supra.*

The wife consents to a procedure which "but for" the consent would constitute an assault. The wife agrees to have her fallopian tubes tied *because* it will make her sterile and the husband refrains from having a vasectomy because his wife is to become sterile. The doctor knew that there was a substantial risk of recanalisation and also knew that neither the husband nor the wife were aware of this fact. To suggest that in these circumstances there could be a meaningful consent to the procedure is not only to misinterpret the meaning of the word but to fall into the trap of equating assault with "violence and harm", rather than a "physical handling without permission".[94] Furthermore, in the situations already mentioned the presence or otherwise of the relevant information is a question of fact to be decided by the court and once it has been shown not to be present the particular issue is decided.

Such has not been the case with respect to medical information-giving and consequent patient participation although there appears to be no rational reason why this should be so. The apparent refusal of the courts to meet the question of patient participation head on has introduced elements of the now discredited concept of *caveat emptor* into an area in which it was never intended to tread. As if overawed by the social status[95] of the medical profession, the courts throughout the common law world appear to have indulged in a degree of uncharacteristic mental and legal gymnastics in order to modify the requirements of disclosure of medical information by a doctor to his patient, and have thereby removed the opportunity for doctor instigated patient participation.

This judicial apprehension has resulted in the strange notion of two categories of consent. The breach of one category gives rise to an action in assault while a breach of the other gives rise to an action in negligence.

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94 *Ibid.*

95 Further this "kid gloves" treatment appears to apply to all actions against medical practitioners. In *Whitehouse* v. *Jordan* [1980] 1 All E.R. 650, 659 Lawton L. J. singled out medical practitioners from the rest of the community:

> The standard of proof which the law imposed on the infant plaintiff was that required in civil cases, namely proof on the balance of probabilities, but as Denning L. J. said in *Hornal* v. *Neuberger Products Ltd:* 'The more serious the allegation the higher the degree of probability that is required.' In my opinion allegations of negligence against medical practitioners should be considered as serious. First, the defendant's professional reputation is under attack. A finding of negligence against him may jeopardise his career and cause him substantial financial loss over many years. Secondly, the public interest is at risk . . . If courts make findings of negligence on flimsy evidence . . . doctors . . . [may adopt] procedures which are not for the benefit of the patient but safeguards against the possibility of the patient making a claim for negligence.

Here Lawton L. J. is not at all inhibited in extending the suggestion by Denning L. J. that different torts should be treated differently, to the assertion that this particular group of defendants should be treated differently.

So ingrained does this approach seem to be that even when disclaiming its accuracy judges appear to follow its result. In *Ashcroft* v. *Mersey Regional Health Authority* [1983] 2 All E.R. 245, 248 Kilner-Brown J. rejects the above as an accurate statement of the law (as did the House of Lords in *Whitehouse* v. *Jordan*) but at the same time he considered previous experience, skill and reputation and the defendant's belief that he had adhered to his usual procedure as sufficient to negate a "formidable argument in support of . . . negligence" and "impressive evidence" and "at the end of Mr Taylor's evidence I would have said that the case against Mr Siegler was established".

The fact that Kilner-Brown J. held that the medical practitioner was not negligent because there was an inherent risk in the procedure pinions him on the horns of his own dilemma. If there was an inherent risk then Mr Siegler was under a duty to disclose it to the patient.

> In situations where the allegation is that attendant risks which should have been disclosed were not communicated to the patient and yet the surgery or other medical treatment carried out was that to which the plaintiff consented (there being no negligence basis of liability for the recommended surgery or treatment to deal with the patient's condition), I do not understand how it can be said that the consent was vitiated by the failure of disclosure so as to make the surgery or other treatment an unprivileged, unconsented to and intentional invasion of the patient's bodily integrity. I can appreciate the temptation to say that the genuineness of consent to medical treatment depends on proper disclosure of the risks which it entails, but in my view, unless there has been misrepresentation or fraud to secure consent to the treatment, a failure to disclose the attendant risks, however serious, should go to negligence rather than to battery. Although such a failure relates to an informed choice of submitting to or refusing recommended and appropriate treatment, it arises as the breach of an anterior duty of due care, comparable in legal obligation to the duty of due care in carrying out the particular treatment to which the patient has consented. It is not a test of the validity of the consent.[96]

It is submitted that this trend is both linguistically fallacious and unjustifiably timorous. To suggest that there can be partial consent and that this equals consent is the same as suggesting that a female can be "a little bit pregnant". To suggest that basic consent satisfies the obligation imposed on a medical practitioner for the purposes of the law of assault and that a failure to provide additional information gives rise to an action in negligence is to add weight to a submission that it is the convenience of the medical practitioner which is to be protected rather than the physical integrity of the patient.

This question has been met head on by the courts in defining consent to sexual intercourse. For consent to be valid there must be an awareness of the nature of the act as distinct from knowledge of surrounding circumstances. Hence in *Papdimatropoulos*[97] where the female consented because she thought the defendant was her husband, the court held that there was no rape because she knew the nature of the act being committed and she had consented to it.

However, the whole basis of the argument in medical consent cases is that the nature of the act — the treatment — is not known by the patient and this lack of knowledge vitiates the consent. This "lightening of the load" might be justified if the provision of medical services was seen as a charitable boon provided by one section of society for the benefit of another.[98] This possibility is typified by such legislation as the Queensland "Good Samaritan" Act[99] and its New South Wales counterpart[100] where mere negligence does not give rise to an action but rather a requirement of proof of gross negligence by the defendant is imposed on the plaintiff. However, over the past thirty years, the medical profession and their representatives have taken an increasingly political and commercial stance and if ever the situation was once to the contrary, medical practice must now be classified in the same light as any other commercial enterprise.

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96 *Reibl* v. *Hughes*, note 18 *supra*, 10-11.
97 Note 88 *supra*.
98 See W. L. Prosser, *Law of Torts* (3rd ed. 1964) Ch. 27, para. 127.
99 Voluntary Aid in Emergency Act 1973 (Qld).
100 Ambulance Services Act 1976 (N.S.W.) s.14A.

The effect of dividing the obligation to disclose information into two parts is to stultify, almost entirely, the movement towards active patient participation in medical decision-making. This is because the medical practitioner is able to defend any action for failing to disclose relevant information brought by a patient on the grounds that current medical standards have been met, or that a reasonable body of medical opinion supports the medical practitioner's action.[101] It is submitted that the disclosure of information relevant to patient decision-making is not a question to be decided by medical standards because it is not purely a medical question. The only exception to this assertion may be where a particularly nervous or highly strung patient could be frozen into inactivity by the presentation of information. Although, when faced with this situation it would be relatively simple for the medical practitioner to offer information while at the same time offering to make the decision on behalf of the patient.[102]

In the same way, in legal practice, where there is a decision to be made whether to accept a settlement or proceed to litigation, commercial considerations are so important that the matter ceases to be "purely legal" and thus outside the competence of the client, and becomes an example of joint decision-making. It is true that in both these cases the experience and training of the professionals involved will guide the ultimate choice made but the assertion that such expertise should be determinative is rejected. As suggested earlier, lawyers will often be delighted to exercise their own discretion but the non-disclosure of possible consequences and alternatives relevant to the resolution of any legal problem flies in the face of "receiving instructions".

Why then do medical practitioners fail to involve patients in the decision-making process? A number of factors relevant to the issue can be identified within the medical education process and the application of scientific method. Traditional medical education[103] has, to a large extent, been relatively student passive. Information is given out by faculty members, learned by the students and returned to the instructors at examination time. When clinical questions are asked the correct response will include the optimum course of treatment, that is, that which produces the best medical result, even though there may be an alternative which an individual patient may elect to follow and which differs from that which is scientifically indicated. In this way, the student at an early stage in his professional development, loses touch with the human element. In the form of a deliberate overstatement the following examples are illuminating in that they show the effect of scientific method on medical practice and

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101 *Bolam* v. *Friern Hospital* [1957] 1 W.L.R. 582 cited in J. G. Fleming, note 36 *supra*, 110.

102 There can be no exceptions to the ordinary requirements of disclosure in the case of research as there may well be in the ordinary medical practice . . . The example of risks being properly hidden from a patient when it is important that he should not worry can have no application in the field of research.

Halushka v. *University of Saskatchewan*, note 31 *supra*, 444. While this acknowledges the problem its solution continues to make the patient an object of the treatment rather than a partner to it.

103 This is usually typified by large classes, especially in the early years of the course, followed by smaller clinical groups in later years.

demonstrate that the medical practitioner no longer ministers to the sick but rather treats the sickness.[104]

> If a doctor sees an ugly, pus-ridden, discolo[u]red wound, for example, he knows from his experience that it is infected. He knows, too, that certain polluting organisms have come into contact with the wound; otherwise it would not be infected. He knows, therefore, that they caused the condition. After a little smearing around in the sore place, some stitches perhaps, a bandage, and a shot of some antibiotic, he goes on to his next case of cause determination. Who is responsible for the wound and its complications? He doesn't know; he doesn't care.
>
> Such an approach can blind the doctor to all outside, pathological factors. If an example is needed, one exists in the case of an Indiana coal mine explosion. A normally robust shot firer who had worked steadily for twenty five years was the victim. He was taken from the debris with two perforations in his skull and a severe scalp wound involving the pericranium. He was badly burned and bruised; both ankles were fractured, one a compound fracture. There were further fractures with much displacement of fragments in each leg above the ankle. X-ray revealed a possible vertebral fracture. When admitted to hospital he was in deep shock; his pulse could not be felt. He lay unconscious and delirious during most of the following fifteen days, unable to take any nourishment except soup and very little of that. On the fifteenth day, he began vomiting convulsively and the next day he died. What in the eyes of the doctor *caused* the death? Blocked bowels. In the widow's proceedings for workmen's compensation, two out of the three doctors who gave opinion soberly assigned their cause to obstructed bowels and opinioned further that the explosion injuries were not the cause of death.[105]

This rejection of non-clinical matters may be based on a belief that they are of secondary importance to the immediate issue at hand or it may be that when faced with the clinical problem they are not even considered. But, whatever the reason, there is ample evidence that the scientifically trained medical practitioner does not allow even matters of great general public interest and importance to deter him from his path of problem resolution. The development of the mechanical heart-lung machine which has enabled medical practitioners to push into areas of treatment previously considered beyond reach has brought with it the need to resolve previously unconsidered questions. The availability of the heart transplant operation, apparently conceptually simple, necessitated a total reappraisal of one of the most fundamental questions that society could ask — the definition of life itself. Yet in advance of the resolution of the question, and at considerable personal risk,[106] many medical practitioners answered the patient's call for help. Similarly, those medical practitioners who have responded to a demand by patients to provide a solution to human infertility have moved the frontiers of medicine so far forward that the law is seen as gasping behind. It may not be surprising that when new procedures are introduced the individual medical

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104 The fact that the humble apothecary was prepared to offer help to those in need gave rise to the emergence of the general practitioner as distinct from the physician or surgeon. This in turn gave rise to the Apothecaries Act 1815 (55 Geo. III C. 194) and was the first step towards modern medical education: M. Poynter, *Medicine & Man* (1971) 108.

105 Small, "Gaffing at a Thing Called Cause" (1953) 31 *Texas L.R.* 630, 647-51.

106 *E.g.*, in N.S.W. any medical practitioner who carries out a procedure which is dependent upon death being defined in terms of the cessation of brain function risks a prosecution for murder because as yet neither the courts nor the Legislature have acknowledged that the death can be measured in these terms.

practitioner is not aware of all the legal ramifications of his actions but it is certainly open to some comment that, once having been made aware of the legal consequences of his actions, there should be no apparent reappraisal. It is submitted that as with the question of patient participation in medical decision-making, the medical practitioner sees his role as problem solver as paramount with the consequent obligation imposed upon others to order their lives accordingly and not to interfere with the progress of medical practice.

It is not as if the legal consequences are unsubstantial and unimportant. Parenthood, citizenship, inheritance, maintenance, legitimacy[107] are all issues which are directly affected by the introduction of new medical procedures and this list does not include a host of administrative questions such as the keeping of and the availability of records, the disclosure to individuals of their origins and the selection procedures for potential participants.

Patient participation requires communication at a non-clinical level between the patient and doctor and this requires both the desire for such participation and training. The medical curriculum has become so crowded that *non-clinical* matters are regarded as of little importance and a distraction from the prime goal of medical information getting. If a student subsequently turns out to be a confident communicator that is more good luck than good education management.

Perhaps the most surprising response that is given by medical practitioners as a justification for a general failure to involve patients in medical decision-making comes in the form of a plea that "I am already too busy and therefore I don't have the time to explain the pros and cons with every patient".[108] In the light of the obligations imposed on fiduciaries in contractual matters and in the anticipated rejection of the suggestion that the practice of medicine is becoming increasingly commercial, such a plea rings hollow indeed. However, it is submitted that the effect of moving information giving into the realm of the tort of negligence is to preserve this attitude as legally acceptable provided it complies with contemporary medical standards.[109]

Why then have the courts taken this apparently soft line with the medical profession? In case after case the judges have expressed sympathy towards doctors either in the awards made against them or by specific reference. In *Murray* v. *McMurchy*,[110] even though the doctor had sterilised a patient without her consent the court refused to award exemplary damages[111] and in *Hart* v. *Herron*[112] Fisher J. said in his summing up to the jury:

> Why would they wish to perpetrate a quite regrettable episode upon a man who is a stranger to them all, as I understand it. For that matter why would Dr Herron want him tricked, want him assaulted and treated against his will and falsely imprisoned, unlawfully? Why would he want that?[113]

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107 D.F.J.J. De Stoop, "Human Artificial Insemination and the Law in Australia" (1976) 50 *A.L.J.* 298.

108 See J.L. Taylor, "Major Current Problems as Seen by the Doctor" in C. Wood (ed.), *The Influence of Litigation on Medical Practice* (1977) 76.

109 *Roe* v. *Minister for Health* [1954] 2 Q.B. 66; *Bolam* v. *Friern Hospital*, note 101 *supra*; *Smith* v. *Auckland Hospital Board*, note 24 *supra*.

110 Note 21 *supra*.

111 *Ibid.*

112 Note 19 *supra*.

113 *Id.*, 48.

It is submitted that motive is entirely irrelevant to the determination of the matter, and is in fact an improper consideration. Yet, in terms of the emotional overtones of assault, the desire to "cure" seems to be a factor which *might* negate the offence. This is especially so when one examines other intentional torts and discovers that the road to court is indeed paved with good intentions.[114] To suggest to any court that the proper test to be applied in a defamation action should be one which arises out of the "usage and practice" of the profession of journalism would be to invoke scorn and ridicule, yet the courts have accepted this in the regulation of medical practice; and to suggest that the protection of reputation is more important than physical integrity is to create an unacceptable and illogical distinction.

This judicial acknowledgement of the special relationship between medical practitioners and society is historically well founded if not rationally or legally justified. There is no doubt that since the dawn of time the medical practitioner has held a special place in society. In prehistoric times and in some communities well after, the "medicine man" served as both doctor and priest. The only explanation for the visitation of a disease on an individual or a community was that it was inspired by a force outside the control of normal man, and therefore required special training to deal with it. Of course, those who were believed to have this special training and therefore able to deal with the unknown, inevitably held a special place in society.[115] It is therefore no coincidence that the proof of the divinity of Jesus Christ is, in many instances, put in terms of this ability to provide cures for the ill and that the cause of the ailments be put in terms of both spirit and sin.[116] Furthermore, it is not surprising, that for over 1000 years after the birth of Christianity those who were "experts" in the healing arts were also members of the clergy. At a time when the knowledge of medicine was virtually non-existent and when the recommended courses of treatment seemed to be more horrendous than the complaint, there nevertheless grew up a separate profession of medicine. The first licences were granted in Salerno in 1140[117] and physicians received royal recognition in England in 1518.[118] The reason for the introduction of the licensing of physicians was "to prevent the deceit of the public by quacks and diverse others"; surely an incredible occurrence in the light of the total lack of medical knowledge of the time, but reflective of the power of the profession even then.[119] What is more, the members of the "medical" profession were able to obtain this special legal status, in line with other groups which had attained special recognition,

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114 An honest belief that the publicity of certain information will lead to reduction of corruption will not justify a disclosure of defamatory material.

115 M. Poynter, note 104 *supra*.

116 Oh Jesus the son of Mary!

. . . .

And thou healest those
Born blind, and the lepers
By My leave
And behold! thou
Bringeth for the dead
By My leave.

A.Y. Ali, *The Holy Quran* (1969) vol. i, 277-78.

117 H. E. Sigerist "The History of Medical Licensurer" (1935) 104 *Jour.A.M.A.* 1057, 1058.

118 *Id.*, 1059.

119 Harvey did not discover the fact that blood circulated around the body until 1628.

even though their level of skill and knowledge in comparison with that of these other groups was vastly inferior. Masons created magnificent stone structures, tinkers made good pots, tailors produced highly efficient clothes as did hatters and cobblers. Smiths, farriers and coopers had all reached a high degree of competence in their respective trades whereas doctors were totally ignorant of even the most basic medical information with a success rate that had not improved for over a thousand years. Throughout the seventeenth century the medical profession managed to maintain its status even in the light of considerable public criticism.[120] It was therefore inevitable that as skills improved and medical education moved from that of philosophy to that of scientific method the community should continue to hold the members of the profession in awe.

Even so, in *Slater* v. *Baker & Stapleton,*[121] a case decided over two hundred years ago, the court committed the heresy of measuring the liability for an intentional tort in terms of the custom of the medical profession. In that case, a medical practitioner used a new device in an attempt to set a fractured leg without obtaining the prior consent for the use of the device, of the patient. The device was unsuccessful and caused the plaintiff considerable pain. Counsel for the defendants expressed great indignation that the medical practitioner concerned should have his actions challenged.

> That Baker has been above 20 years the first surgeon in St Bartholomew's Hospital, reads lectures in surgery and anatomy, and is celebrated for his knowledge in his profession as well as his humanity; and to charge such a man with ignorance and unskilfulness upon the records of this Court is most dreadful.[122]

The court held that an action of trespass *vi et armis* would lie if a procedure was carried out without the patient's consent but in so doing held that the requirement arises out of

> the usage and law of surgeons; then it was ignorance and unskilfulness in that very particular, to do contrary to the rule of the profession, what no surgeon ought to have done; and indeed it is reasonable that a patient should be told what is about to be done to him, that he may take courage and put himself in such a situation as to enable him to undergo the pain.[123]

It may be an unfortunate choice of words that places the patient in the position of passive supplicant but there can be no doubt that even here, in 1767, we witness an example of the embryonic law of negligence intruding into a womb which was not intended to provide it with nutrition.

The requirement of consent as a defence to an assault arises by the operation of law and not at the whim or behest of the medical profession and reference by the courts to the requirement of the profession may serve as an example of medical ethics, but the fact that it should serve as determinative is to unnecessarily elevate the medical profession over other groups and individuals.[124]

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120 It is reported that during the Great Plague of London in 1665 that most of the physicians and surgeons fled and left the general population to their own devices.

121 [1767] 95 E.R. 860.

122 *Id.*, 862.

123 *Ibid.*

124 *Ashcroft* v. *Mersey Health Authority*, note 95 *supra*, where the communication to the patient of known serious risks was not even considered sufficiently important to be raised as an issue.

Unfortunately the courts have shown that they are either unable or unwilling to recognise that the plea for patient participation in medical decision-making is not a threat to the fabric of medical services in the community. At the same time it is probably unrealistic to expect those who have been practising medicine for many years to change their methods overnight. The least traumatic way of introducing this change of method is to make it an integral part of the clinical training of medical students so that in a relatively short time it will become the requirement of the profession with the result that good law will coincide with good medicine.